20 JANUARY 2001

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

New look PSNC: Axon and Dove to step down

Team leader sought for DoH medicines management pilots

RPSGB progresses on regulatory reforms

Happy birth control day to the Pill!

Kingfisher may put Superdrug up for sale

Update: *preventing stroke a high priority*

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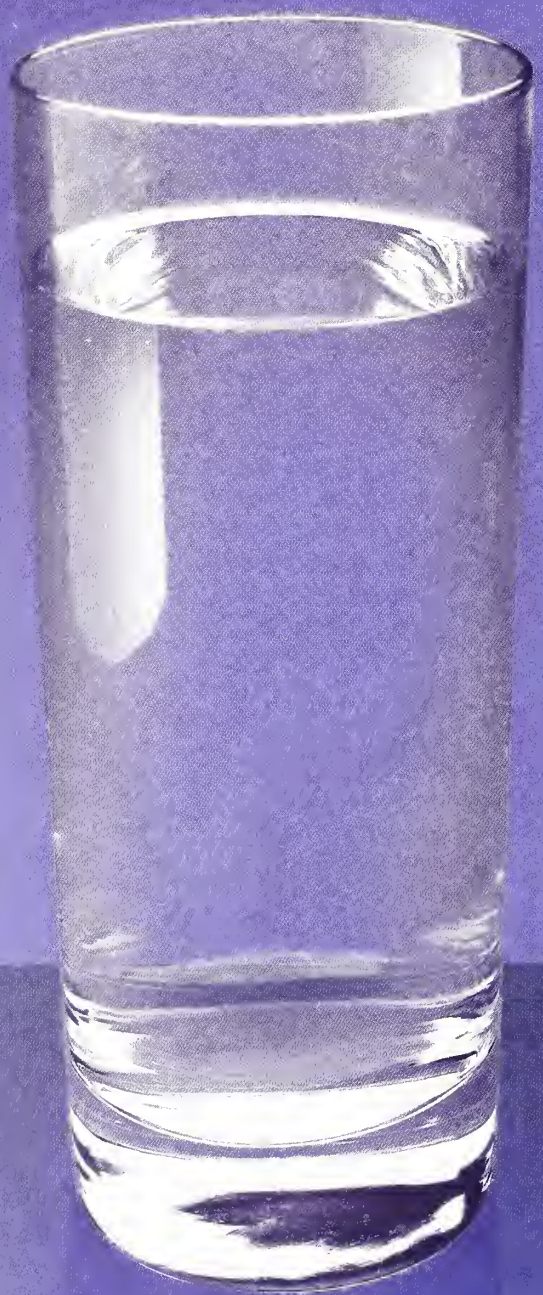

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CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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REGULARS

COMMENT

This has been the week for the announcement of organisational change. PSNC is bidding farewell to Steve Axon and plans to appoint a chief executive (p4). There is to be a new (non-executive) chairman from outside the Committee's membership, although his name remains a closely guarded secret. Let's hope PSNC is more successful in finding a CEO of the right calibre than it was the last time it went down this particular road. Dr Jim Smith moved into the chief pharmacist's office at the DoH and marked the event with an interview on Radio 4's 'Today' programme (an indication that pharmacy is gaining a higher media profile - a view reinforced by an article in Wednesday's *Guardian* which argued that the Government 'must help combat the multiple threats which could kill off a key element of primary care - the local chemist's shop'). The RPSGB has also flagged up fundamental changes that are on the way. Disciplinary reforms and competence-based practising rights will be in place by the end of the year, and a shake up of the Society's constitution, which will see substantial lay representation on Council, is anticipated (p6). Pharmacists whose contact with the professional body is limited to the annual payment of their retention fee could be in for a shock. The Society is also cautiously optimistic that its lobby for pharmacy to be listed as an exempt profession under the Competition Act is making headway. Should this wish be granted the Society will be in a much stronger position to set professional standards and enforce them - something it struggles to do at present. The RPSGB is working towards a position where it will be considerably more empowered in its twin role as the profession's advocate and its disciplinarian. If it wants to retain that unique position it must be careful not to abuse it. There is talk of splitting the role, but most pharmacists see little benefit in having two separate bodies, as does the medical profession. But that could change if the whip is cracked too hard.

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Editorial secretary Jan Powis
Editorial (tel): 01732 377487; (fax): 01732 367065; chemdrug@unitedbusinessmedia.com
Price List Colin Simpson (*Controller*), Darren Larkin, Maria Locke
Price List (tel): 01732 377407; (fax): 01732 377559
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Advertisement department secretary Elaine Steele
Advertising (tel): 01732 377621; (fax): 01732 377179
Production Katrina Avery
Publishing director Fergus Wilson
Associate Publisher John Skelton *FRPharmS*

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Home visits funded by social services

Pharmacists in Stafford are offering home visits, funded by social services, to people with medication problems.

About 18 pharmacists receive £25 an hour for visiting housebound patients, who have been referred by social workers. In an earlier project in North Staffordshire, pharmacists visited elderly patients; the latest scheme has been extended to anyone with medicines-related problems such as compliance, or the mentally ill.

Social services will pay £6 a month for pharmacists to fill monitored dosage containers, if patients meet the criteria and cannot afford to pay. Some patients are paying for this service themselves. Accredited pharmacists have also been trained to carry out "brown bag" medication reviews and remove unwanted medicines from the home.

Andrew Morrison, chairman, Stafford Pharmacists Association, hopes the £30,000 funding will continue for at least another year. He said: "The scheme is tied in with a campaign on accident prevention. If we can reduce medicines-related accidents we can save primary and secondary care costs, and reduce the need for admission to residential homes."

Next month there will be discussions on extending the scheme to referrals from the voluntary sector, such as Age Concern and charities for the blind.

"We have built a lot of bridges with social services, who had previously no idea what pharmacists could offer," said Mr Morrison. "We could suggest such schemes to the primary care group as a priority for ongoing funding."

PSNC restructuring starts from April

The Pharmaceutical Services Negotiating Committee is to introduce a new structure of committees and leadership from April.

A new chief executive officer will be appointed, while the chairman's position will be modified to that of non-executive chairman.

Making way for these new positions are Stephen Axon, who will be retiring from the post of general secretary in July, and Wally Dove, who will step down as chairman soon after the PSNC/Local Pharmaceutical Committee Conference in March. However, Mr Dove says he is prepared to stay on as a member of PSNC, if he is re-appointed as an NPA nominee to the Committee.

Five new sub-committees are also being established as part of the "major internal reforms". The new sub-committees, which start work on April 1, and their chairmen are as follows:

- Contract and planning - Neil Maxwell
- Marketing and public affairs - Alan Tweedie
- Audit and review - Roy Carrington
- Resource development and finances - Steven Williams
- Strategic planning and policy - Philip Parry.

The change comes as a response to the Audit Committee report on new ways of working at PSNC, which was approved last June. A modernisation review of PSNC had been proposed by Mike Smith, shortly before he left PSNC. Roy Carrington was appointed chairman of the Audit Committee with the task of reviewing how PSNC operated and what changes could be introduced to meet the requirements of the changing NHS and of pharmacy contractors.

His committee's report was approved last June and, since then, Mr Carrington has chaired the implementation committee working to bring about the proposed changes.

The sub-committee chairmen were elected by the main PSNC committee at its meeting last week. The appointment of CEO and non-executive chairman will take place over the next few weeks. Mr Axon will retire from his post at the end of July after 29 years at PSNC, but will be retained as a consultant.

The new CEO will have wide-ranging responsibilities, leading PSNC negotiations at all levels with the Government and the NHS. In addition, the appointee will be responsible to PSNC for the performance of officers and staff.

Meanwhile, the new chairman will be appointed from outside the Committee's membership. The person will chair PSNC meetings and will "assist in building and fostering the committee's relationships with relevant NHS stakeholders and others". Further details relating to this appointment have yet to be finalised.

On Monday, Mr Carrington suggested that the new sub-committee structure is geared to today's requirements in a modern NHS. As well as leading PSNC in all aspects of negotiation, he said, the new CEO will manage the office and lead the committee.

"We are looking for someone from a strong background who may or may not be a pharmacist. We are looking for someone who will be comfortable talking with government, the major multiples and with other pharmacists."

While it is not essential that either the CEO or chairman post is filled by a pharmacist, PSNC agrees that at least one should be a pharmacist.

Commenting on his retirement, Mr Axon said that he had worked for PSNC for 29 years. "There's no right time, but looking at the Government's plans - it's a ten-year plan - I have no intention of going beyond 60. I believe it needs someone who can carry it through for a ten-year period. With the combination of the post, it is probably the right time.

Stephen Axon

Wally Dove

Mr Dove had indicated to PSNC early on his intention to step down this year, but has agreed to stay on until the new person takes up the appointment. "The most important thing is to ensure a smooth change-over," he said.

Although PSNC may be reforming its own workings, delegates at the LPC Conference meeting on March 12 will be able to debate the touted merger between PSNC and the National Pharmaceutical Association.

Leicestershire and Warwickshire LPCs' motion calls for serious discussion on the merger. PSNC points out that it agreed in the Audit Committee report that one of the tasks of the newly appointed CEO will be "to consider the possibility of a merger with the NPA and/or other organisations and to conduct open and frank discussions".

Mr Dove is expected to give more information on the wider implications of such a move in his report to the LPC conference.

Call for papers for BPC and nominations for *C&D* medal

The first call for papers for the British Pharmaceutical Conference, including the *C&D* Conference Practice Research Medal, has gone out.

The theme for this year's BPC, which takes place in Glasgow from September 23-26, is 'Global pharmacy - science in the service of patients'. Highlights of the conference will include:

- an address from a senior government figure
- sessions on global prescribing; tuberculosis, AIDS and medicines management
- a ministerial address on the NHS Plan
- the pharmacist's role in coronary heart disease.

Nominations or applications for the 2001 *C&D* Conference Practice Research Medal should be made by March 31. The £1,000 award and medal is intended to recognise individuals up to the age of 45 who have made significant contributions to the field of pharmacy practice research and have the potential to become leaders in the field.

Further details of the award, which is open to non-pharmacists as well as pharmacists, and who need not necessarily be based in a school of pharmacy, are available from: Cathryn Andrews, Practice Research Secretariat, Royal Pharmaceutical Society, 1 Lambeth High Street, London SE1 7JN. Details are also listed on our web site at *www.dotpharmacy.com*

Stoate defends pharmacy corner over Health Bill

Dr Howard Stoate: fighting pharmacy's corner

Howard Stoate MP has warned the House of Commons of the damage changes to the control of entry could cause to the "fragile but essential network of community pharmacies".

During the second reading of the Health and Social Care Bill last week, Dr Stoate voiced his concerns about Clause 31 in the Bill allowing for the suspension of control of entry regulations to allow for new services. Such a move might have a serious impact on existing pharmacists and pharmacies in the area, he warned.

"I want the Standing Committee to consider whether it would be reasonable to include a provision that allows health authorities to take account of the effects of the arrangements on existing pharmaceutical services," he told the Commons. "Rather than simply suspending the list and allowing new contractors to establish services, which might be in direct competition with existing contractors and might, therefore, have a destabilising effect, we should allow the authorities to take careful account of the effect of the new arrangements.

"I would hate a brand new arrangement to be implemented that appears on the face of it to be a good idea, but which destabilises existing contractors and worsens the service for patients."

Earlier, Dr Stoate, who chairs the parliamentary All-Party Pharmacy Group, had welcomed the Bill's proposal to extend prescribing rights to pharmacists, not just to issue repeat prescriptions, but to supply *de novo* prescriptions for certain classes of drug.

He also welcomed as "a good idea" the proposals for remote provision of medicines through the internet, mail order or through a delivery service to patients' homes. "For all sorts of reasons, some patients have difficulty in getting a prescription, taking it to the pharmacy and collecting their drugs, which may cause considerable hardship," he explained.

Shadow health spokesman Dr Liam Fox also welcomed the extension of prescribing rights to pharmacists. Some of the Government's ideas "very much echo our own ideas on prescription-first medicines and allowing pharmacists to re-prescribe, once the initial prescription has been given by the doctor", he said.

He was concerned that he had been unable to obtain an inhaler for his asthma without seeing his own GP for a prescription. Saying such treatment was "nonsense", he argued: "Simply taking out common prescriptions, such as those for asthma, would stop about 30 million repeat prescriptions going across doctors' desks."

Action Team leader to manage medicines

The National Prescribing Centre is advertising for a project team leader to run the new national medicines management services programme.

The 'Pharmacy in the Future' document proposed an Action Team to co-ordinate the introduction of medicines management services in each primary care group/trust by 2004.

The team leader, probably a senior pharmacist, will be based at the National Prescribing Centre in Liverpool.

A three year contract will go to the successful candidate, who "should have a strong and demonstrable track record in the promotion and delivery of cost-effective prescribing and medicines use within the NHS and, particularly, primary care" (see p26).

The person appointed will establish close working relationships with a separate national medicines management pilot in community pharmacies, proposed by the Pharmaceutical Services Negotiating Committee.

The Action Team will provide knowledge, expertise and training initially for 20-25 PCGs, using techniques that the National Primary Care Development Team is already applying to other aspects of primary care. Next month the Department expects to invite PCG/Ts to take part in the programme, which should be up and running by the autumn.

The Department is establishing a multidisciplinary advisory group to consider the overall aims, to monitor progress and advise on roll out. The group will include representatives of the pharmacy, medical and nursing professions, NHS management, patient and consumer bodies, and industry.

PSNC pilot reaches final tender stage

The Pharmaceutical Services Negotiating Committee will shortly receive final tenders from academic bodies to run and evaluate a medicines management project through community pharmacies.

The Department of Health has agreed to fund the project, involving patients with coronary heart disease, but negotiations are continuing on the amount.

PSNC initially put in a £1.8 million bid, but an NHS Executive spokesman told *C&D* on Tuesday that the final figure would depend on factors such as the tenders received and the costs of running the pilot sites. The trial is expected to start this year.

GP pharmacy raises fears of closures

Surrey pharmacists are concerned about a personal medical services pilot in which GPs are buying a pharmacy that will provide repeat dispensing to all patients.

The GPs are refusing to open the service to other local pharmacies, claiming this would compromise patient confidentiality. Data will be transferred electronically between the surgery and pharmacy.

Kingston & Richmond Local Pharmaceutical Committee is worried that the pilot, which has been sanctioned by the health authority and at regional level, might harm the pharmacy network in the area. Terry Silverstone, LPC secretary, told *C&D*: "We are not just trying to protect pharmacy but want to do what is best for patients. If other pharmacies suffer and end up closing as a result of this new pharmacy, then services to the community will be depleted. Patients should always have a choice of which pharmacy to visit."

He did not know when the pharmacy would open and declined to reveal the name of the GP practice.

The LPC put a resolution to the LPC Conference in March expressing concern about GPs acquiring pharmacies with the intention of directing their patients' repeat prescriptions via electronic transfer. The Pharmaceutical Services Negotiating Committee has accepted the resolution and is pursuing it with the Department of Health.

IN BRIEF

RPSGB Council intentions

Wally Dove, soon to step down as PSNC chairman, intends to stand for election to the Royal Pharmaceutical Society Council, he announced on Monday. Last week, former Council member Ashwin Tanna also said he intends to stand in the May elections as he is unhappy about the way the editorship of the *Pharmaceutical Journal* has been handled.

NCSO endorsement addition

The Department of Health and the National Assembly for Wales have agreed to allow NCSO endorsements for the following additional item for January prescriptions: quinine bisulphate tablets 300mg.

Health education book

The second edition of the 'Handbook of Pharmacy Health Education' has been published. The book provides information suitable for use by health professionals, and particularly pharmacists, in promoting healthy living. Areas covered include a general overview of health promotion, as well as issues such as dietary management, dental healthcare, drug abuse, contraception, petcare, sports, smoking and alcohol abuse. Copies of the book (ISBN 0 85369 471 0, £35) can be ordered from the Pharmaceutical Press, PO Box 151, Wallingford Oxon OX10 8QU. Tel: 01491 824486.

Life After Stroke Awards 2001

Pharmacists are being asked to help publicise the Stroke Association's annual award. Sponsored by Solvay, there are seven different categories including an award for carers, an art award and one for children who have had a stroke. Nomination forms are available from The Stroke Association on 01604 623934 or from their web site at *www.strake.org.uk* or from Kelly Sherry at Solvay on 02380 467 088.

Parliamentary men's health

An all-party group specialising in male health problems is to be established before the end of the month at Westminster. Dr Howard Stoate, who is expected to be its chairman, said he wanted the group to raise the profile of male problems, including prostate cancer and heart disease.

Latest RPSiS briefing

The Royal Pharmaceutical Society in Scotland has issued its latest briefing papers to Scottish parliamentarians. The first highlights the contribution made in the 150 years the Society has been represented in Scotland as well as modern advances in medicines. The second discusses the key role pharmacy can have in the Scottish NHS plan.

New CPO sets out Bill's prescribing possibilities

Dr Jim Smith, the new chief pharmaceutical officer at the Department of Health, said pharmacists may take full responsibility for prescribing under new powers in the Government's Health Service Bill.

Speaking about the powers under the Bill to extend prescribing by pharmacists, Dr Smith said on BBC radio: "The legislation might give them the scope to be able to extend that and to take full professional responsibility for that prescribing."

Dr Smith said the extra prescribing by pharmacists could help relieve pressure from GPs but he also dealt with the controversy raised by the *Daily Mail* which sent a girl of 15 to chemists and found that six out of seven gave her the morning after pill against official guidelines.

"This is a difficult area for pharmacists. We are anxious that pharmacists do make a contribution to the problem of unwanted pregnancies. It is difficult for family planning services, if someone is intent on deception. Pharmacists are very well aware of the age issue. We are doing everything we can to ensure that this is handled responsibly and age is ascertained before these sales are obtained," he said.

He acknowledged that there was a trend away from independent pharmacists in the High Street but showed no hint of any action to reverse it. He said: "There is a trend towards concentration of pharmacies in multiple chains. However, I would say the service provided in multiple chains is very high."

The Bill going through Parliament leaves open much of the detail on prescribing by pharmacists to be filled in later. Dr Howard Stoate, the Labour MP and family doctor, announced that the All Party Pharmacy Group which he chairs will be pressing Alan Milburn, the Health Secretary, to allow pharmacists to provide up to six repeat prescriptions depending on the treatment. The GP should have the right to stipulate how long chemists should be allowed to issue repeat prescriptions, he said.

"I would like to ensure that the GP was satisfied with the length of time he allows the pharmacists to issue repeat prescriptions.

"It could be that the GP would say that after a course of treatment, he wants to see the patient again in six months," said Dr Stoate.

He said electronic checks on prescriptions by pharmacists could also help to pick up patient compliance with courses of treatment by showing whether a patient had delayed before returning for a repeat prescription.

Society's reforming steps

The Royal Pharmaceutical Society should soon be ready to submit legislative proposals to the Government on disciplinary reforms and the introduction of lifelong learning, following a special meeting of Council and staff last week.

The framework to introduce the first tranche of the Society's disciplinary reforms and competence-based practising rights will be established under a Health Act Order in Council by the end of the year. Further changes would await a second Order in Council.

The Society also expects the implementation this year of long-awaited regulations establishing a Health Committee to deal with pharmacists who are unfit to practise because of illness or other impairment.

The Society's Health Act Working Party will put recommendations to the February Council meeting, after which the Society will submit proposals for an Order in Council to the Government. Any proposal taken forward by the Government will be open to consultation with the affected professions.

The Society has been working closely with the Department of Health to ensure that the pharmacy develops in line with the Government's agenda on transparency and accountability for professional self-regulation.

Regulation reforms are well under way, affecting all health professions through the Health Regulators' Council umbrella body, of which the Society will be a part. A key issue is lay involvement in functions and organisations that focus on the protection of the public or meeting public interests. Proposed regulatory bodies for medical, nursing and other professions, such as physiotherapists, chiropodists and dieticians, would allow a professional majority of no more than one.

The Government also intends to link continuing registration of professions to demonstrable competence, a move the Society has welcomed in the interests of the public.

More rebellion against POD checks

Two local pharmaceutical committees in the North West are to rebel against point of dispensing checks at the LPC Conference on March 12.

Liverpool LPC has urged the Pharmaceutical Services Negotiating Committee to hand back the £10 million for this purpose to the Department of Health, with the clear message: "Do it yourself; we want nothing more to do with POD exemption checks."

St Helens & Knowsley wants POD checks to cease until a new agreement, acceptable to all contractors, can be negotiated. The LPC has asked PSNC to tell the Department that the profession is no longer willing to accept any responsibility for checking.

The fee paid "is poor compensation for the time and effort the contractors expend and the abuse they suffer in enforcing exemption checking", the LPC comments. The advent of paperless prescribing, coupled with the "deplorable loss" of revenue from prescription switching, are further reasons to stop the service.

But PSNC recommends that the meeting rejects these resolutions. Returning the £10m global sum allocation would reduce the remuneration payable to contractors. And POD checking is included in the Chemists Terms of Service, so PSNC says it would be acting unlawfully if it advised contractors to stop.

Manchester LPC is to urge PSNC to negotiate a realistic fee for exemption checks, to which PSNC comments that the POD proportion of the remuneration payable to contractors is £12.6m, equivalent to about 4p per form, whether exempt or not.

But PSNC is supporting a resolution, from Dyfed Powys, deploring the Government's failure to recognise contractors' increased productivity. PSNC welcomes the chance for conference to debate the matter and "send a clear message to government".

Camden & Islington believes that neither the Department nor the health authorities are making any attempt to ensure that primary care groups act in even-handedly when disbursing funds. So far PCGs have allocated only a small proportion to practitioners other than GPs. Again, PSNC would like LPCs to share experiences and help PSNC to formulate policy for a central approach to the Department or local approaches by LPCs.

Other resolutions for debate include:

- Payments made to Essential Small Pharmacies Scheme pharmacies for prescriptions marked "urgent" should not be included in the ESPS calculation.
- PSNC should negotiate a national scheme for prescribing from community pharmacies, for example, emergency contraception on the NHS.

PSNC has accepted resolutions on the NHS pharmacy programme without the need for debate at the LPC Conference. The Committee agreed to take action on a call to modernise the role of dispensing technicians and counter assistants to take advantage of 'Pharmacy in the Future', together with another resolution to introduce continuing professional development in stages to prevent potential loss from the register of part-time locum pharmacists.

Paisley contractor gets LHCC chair

Asgher Mohammed, a pharmacy proprietor from Glasgow, is the first pharmacist in Scotland to become chairman and clinical lead of a local healthcare co-operative, the equivalent of a primary care group north of the Border.

He took up the post at Paisley LHCC on January 1. He will oversee the development and delivery of integrated care services for a population of 85,000, which includes 13 GP practices, 18 dental practices and 19 community pharmacies.

Over the past three years Asgher has promoted pharmacy involvement in the LHCC. He was elected pharmacy representative on the LHCC executive group and set up the Renfrewshire and Inverclyde Pharmacy Network.

He will be working for the LHCC for three sessions a week, at a rate negotiated between himself and the Trust board, where he is responsible to the medical director. He advocates a patient-centred approach, and will work to promote successful teamworking.

The appointment was announced at the Scottish LHCC Pharmacists Conference in Dunblane last weekend (see p20).

Asgher Mohammed

INDUSTRY VIEWPOINT

POM to P needs new initiatives

The Government has made it clear in the NHS Plan that it wants to see more 'POM to P' switches, but the record shows that it is difficult for manufacturers to achieve an acceptable return on the investment needed to launch a 'POM to P' medicine over the counter.

The Medicines Control Agency has indicated that it is disappointed with the slowdown in switches. A new approach is needed to restart the process.

Emergency hormonal contraception is significant in many ways. For the Government, it shows a determination to allow easier access to an important medicine. For patients it offers choice and convenience. For the manufacturer it offers a new channel of supply.

"For pharmacists it offers a superb opportunity to show their true worth"

For pharmacists it offers a superb opportunity to show their true worth. If the Government, patients and the manufacturer feel a positive benefit from this switch the long-term winner will be pharmacy.

The *Daily Mail* reported that test purchases made at a number of South London pharmacies resulted in an under-age girl being able to buy Levonelle. It was to be expected that certain elements of the press would try to prove that pharmacists were not following guidelines.

The lesson to be learnt is that pharmacists must not only follow the Royal Pharmaceutical Society's guidelines, but they must also exercise due caution – although that caution should not lead to avoidance. It would be a great pity if pharmacists were 'scared off' from selling Levonelle to appropriate patients.

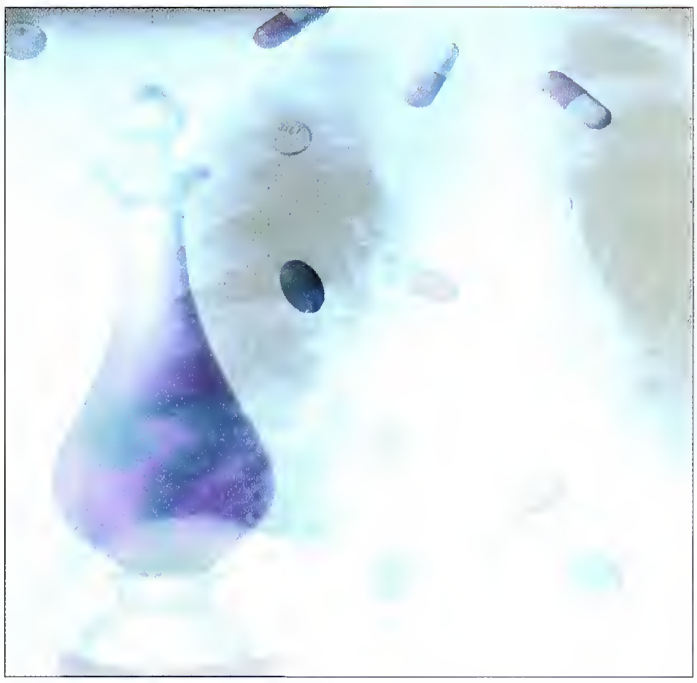
The ideal 'POM to P' molecule has a strong ethical heritage, and a well-known brand name. Staff training and appropriate advertising are also important but the vital ingredient is proactive support from pharmacists.

The deregulation of Levonelle suggests that future switches will not be limited to minor ailments. This heralds a new range of Pharmacy medicines. With RPM under threat and grocers taking more of the GSL business, pharmacists should actively support new and existing P medicines.

Contributed by a senior industry manager

Xrayser

Topical Reflections



A prescription for confusion?

Increasing the number of health professions responsible for prescribing drugs may seem – at least to those on whom the privilege is being conferred – to be a good thing. It is an excellent route to achieving greater professional responsibility, and it should reduce surgery workloads and improve patient care.

However, as the number of prescribers increases, so do the problems of accountability. The other day I received a faxed prescription request from a nurse prescriber to deliver some dressings to a housebound patient, with a promise to drop the prescription in to me the next day.

Two days later and still no prescription, so I phoned the nurse-prescribing contact telephone number. The culprit was on leave and only a message could be left. There was no record of her request, and even though the patient's doctor was willing to repeat the prescription there was no record there either!

I knew the prescription existed – after all I had a faxed copy – so there was no point in the surgery issuing a copy, and in any case their prescribing budget had already been top sliced to pay for nurse prescribing, so it was no longer their responsibility!

Eventually the script turned up with suitable apologies after the guilty party returned from leave, but what a mess and what a black hole in a system designed to improve efficiency. And this is with only one extra prescribing profession. What happens when physiotherapists, chiropractors and chiropodists as well as pharmacists join the party?

Where will clinical responsibility lie and whose responsibility will it be to collate medical notes and ensure all practitioners have instant access to each other's decisions?

Then there are the patients. If they are confused now, then unless all professions pull in the same direction they could end up piggy-in-the-middle with everyone blaming each other when mistakes are made.

Nurse prescribing has given me a taste of things to come. Fine when everything works but in danger of leaving the patient high and dry when it doesn't!

A more diplomatic approach needed

I was recently sent a cutting of a letter published in the *Birmingham Evening Mail* (January 4). Headlined 'Rein in our GPs, pharmacists could do a much better job', David Crewsdon of Solihull suggested that GPs were over-paid, over-pampered and inefficient. Far better to remove resources from GPs and re-allocate them to pharmacists and hospital doctors!

I am all in favour of good publicity, and a demonstrable understanding of the problems affecting the practice of community pharmacy is a bonus, but I have to disagree with part of the message.

I am not against GPs. On the contrary, I think most GPs do an excellent job under extreme pressure, and in the main their ancillary staff are equally supportive.

I would suggest that David should not attack GPs quite so blatantly (all professions have their mavericks), but use his obvious lobbying talents to promote the case for a real involvement by community pharmacists in the treatment of minor ailments and the promotion of health improvement initiatives.

The 'Pharmacy in the Future' plan and the Scottish equivalent are still bare bones, but vociferous public pressure to resource those plans adequately would do more to enable pharmacists to fulfil their potential than could ever be achieved by linking that progress to a diminished role for GPs.

So will I get any credit for discontinued line?

In a letter dated January 10 and addressed to all health professionals, Janssen-Cilag has notified me that after an extensive risk-benefit assessment it has decided to discontinue Droleptan.

I cannot argue with the decision or with the two months notice of discontinuation which should allow an orderly change of medication for patients on long term treatment. However, in the attached question and answer sheet there is no indication of what action Janssen-Cilag will take after March 31 to compensate pharmacists for residual stock.

Two and a half months may seem adequate time for me to use the 50 tablets I have in stock but I presently have no patients on regular medication and the probability now of receiving any new scripts must be very low. Come April 1, I anticipate having £13.50 of unusable stock. I would like to know now whether Janssen-Cilag intends crediting that stock in full?

Pharmacy to help tackle HIV in Scotland

Pharmacies are likely to be involved in new initiatives to tackle HIV infection in Scotland.

Needle exchange and methadone maintenance schemes will be reviewed by health boards to ensure they are providing adequate harm-reduction measures for injecting drug users. Other recommendations of the HIV Health Promotion Strategy Review Group's report include:

- antenatal screening for HIV to be offered to all pregnant women
- encouraging gay men to undergo HIV testing and provide access to 'gay-friendly' sexual health clinics
- reviewing advice for those travelling overseas on the increasing risk of picking up HIV abroad.

An extra £7 million will be made available from the Health Improvement Fund over the next four years to strengthen services.

Announcing the new initiative, Scottish health minister Susan Deacon said: "The spread of HIV has been brought under control in Scotland in comparison with most countries in the world. This report recognises that much more needs to be done if we are to see the number of new cases of HIV reducing year on year."

- Patients in Scotland will now be asked to provide proof of entitlement to free NHS dental treatment or help with dental charges in an attempt to cut the cost of patient dental fraud in Scotland.

Boots seeks high-profile pharmacist

A pharmacist with "several years' experience in a high-profile management role" is required by Boots to fill the new position of Head of Clinical Governance.

The successful applicant will be responsible for developing and implementing a clinical governance strategy for the company. The role will include reviewing existing pharmacy standards, designing quality management systems and developing best practice.

Superintendent pharmacist, Digby Emson, said: "Clinical governance is at the heart of our business and is fundamental to the NHS plan for pharmacy. We have a commitment to provide continuous improvements to the quality of the professional services we offer. This new role will be significant in delivering those improvements."

The post is being advertised this week and will be based at the company's head office in Nottingham.

PSNC lobbying on Health Bill – but still no contract

Pharmaceutical Services Negotiating Committee was to meet with health minister Lord Hunt on Wednesday to discuss the implications of the Health and Social Care Bill currently going through parliament. However, PSNC has received no indication yet of when it will see the new pharmacy contract promised by Lord Hunt for early in the new year.

In terms of the Bill, PSNC has already written to the NHS Executive to express concern for existing contractors with regard to changes in the control of entry. It is also concerned that local pharmaceutical committees should be specifically mentioned as one of the bodies that should be consulted about local pharmaceutical services.

However, PSNC says it is pleased to see that legislation will allow the provision of services across borders as this will help address the problems of oxygen supply. It will also mean that it may allow minor re-locations across borders where health authorities' jurisdictions run down the centre of a street, for example, when a contractor wishes to move the business across that street.

On Monday, PSNC chairman Wally Dove said he hoped to clarify the Bill's proposals relating to accreditation, for example, of e-pharmacy businesses. There will be third party accreditation, but it is not clear who will be providing it, he said. With regard to HAs being required to hold lists of practitioners, including pharmacists, who may be employed by contractors, Mr Dove sees significant implications for the large multiples and believes the Department of Health will need to create a national data base.

Other areas needing clarification include: the powers of the newly established patient forums to inspect pharmacy premises, along with other healthcare premises; the implications for data collection such as patient medication records and onward of transmission of anonymised data; and links with social services and care trusts.

Referring to the promised new pharmacy contract, Mr Dove said that there were no signs that the proposals had been completed. However, he added: "I think the Bill will enable a broad range of things to be done, so I do not think the Bill will affect the contract."

Supervision PSNC approved a report, at its meeting last week, from the Supervision Working Party. The report sets out PSNC's policy on supervision of pharmacies and proposed requirements to allow community pharmacists to provide a wider pharmaceutical service.

The report has been sent to the NPA, CCA and Co-operative Pharmacy Technical Panel for comment. PSNC hopes to publish details next month.

However, an indication of the contents of the report is contained in PSNC's response to a motion to be debated at the LPC Conference in March. North Yorkshire LPC is calling on PSNC to recognise that supervising the dispensing of drugs and the provision of appropriate related advice will remain the principal task of community pharmacists for the foreseeable future.

In its comment on the motion, PSNC said that it considers the role of the community pharmacist as being concerned with a range of issues, of which supervision of dispensing is only one, "albeit a very important one".

"In order to have the flexibility to meet the challenges presented by the Pharmacy [in the Future] programme, and the pending legislation, PSNC considers that flexibility in negotiations is of vital importance, and that it is, therefore, inappropriate for the profession to be tied to any specific priority."

PSNC Dinner Lord Hunt will be the guest of honour at the PSNC dinner following the LPC Conference on March 12. PSNC will not now be holding a seminar on the Health and Social Care Bill on the Sunday prior to the LPC conference as had been hoped.

LPC constitution PSNC has approved a change to the model LPC constitution relating to co-option procedures. The new paragraph, which can be adopted by LPCs, allows registered pharmacists other than pharmacy contractors to be co-opted to fill any casual vacancies, should insufficient contractors stand for election or agree to be co-opted to the LPC where there is a vacancy. This should allow pharmacist employees to be co-opted onto the LPC.

Confusion surrounding MMR

Confusion over the measles, mumps and rubella (MMR) vaccine may not have been helped by the plethora of reports from various sources last week.

The DoH's first press release, issued on January 11, was in response to the paper published in last week's *British Medical Journal* about health professionals' attitudes to giving a second dose of the MMR vaccine. This paper was widely reported in the national press.

On January 12 another press release said that it welcomed the advice issued by the Committee on Safety of Medicines and the Joint Committee on Vaccination and Immunisation that the combined MMR vaccine remains the safest way to protect children.

This weekend, community pharmacists should have received, via their local health authority, a message from the Chief Pharmacist's Office repeating the advice from the CSM and JCVI but mentioning a different paper due to be published in 'Adverse Drug Reactions' on January 22. This paper will discuss the introduction of the MMR vaccine in 1988.

Finally, a Finnish study, published in *The Paediatric Infectious Disease Journal* in December, was discussed on Radio 4's Today programme. This follow-up study of three million vaccine doses did not detect any link with inflammatory bowel disease or autism.

- The DoH is currently producing a new leaflet for parents on MMR and an updated factsheet for health professionals. Meanwhile, up-to-date information for the public and health professionals is available at *www.immunisation.org.uk*

DoH relaunches telemedicine plans

The Government has relaunched its information technology strategy for the NHS.

Announcing an extra £700 million investment as part of its new strategy, 'Building the information core: implementing the NHS Plan', the Department of Health says that electronic patient records will be in place allowing patients to have facilities for telemedicine by 2005. This means people could consult with their GP or a consultant without the need to leave home.

A new Telemedicine Information Service web site, *www.tis.bl.uk*, is seen as a key element, giving information on over 120 projects, an e-mail discussion list, plus telephone enquiry and current awareness services from the Medline database.

Besides the investment in video between surgeries and hospitals, ambulances will also be given video and monitoring equipment so patients can receive specialist care while on the way to hospital.

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Senokot TV in 2000 grew national sales by 43%
Stock up now for 2001 TV by calling telesales on freephone 0500 208 209
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Script specials

Almogran for migraine

Lundbeck is launching Almogran (almotriptan), a selective 5-HT1 receptor agonist, for acute treatment of migraine headache with or without aura.

Almogran is available as 12.5mg tablets in packs of three, six or nine tablets. The recommended dose is one tablet but a second dose may be taken after two hours if symptoms reappear. Two tablets in 24 hours is the maximum recommended dose.

Almotriptan is contraindicated in children under 18 years of age and, as with other 5-HT1 agonists, should not be used in patients with a history of ischaemic heart disease, severe or uncontrolled hypertension or severe hepatic impairment.

Concomitant administration of almotriptan should be avoided with lithium, ergotamine and other 5-HT1 agonists.

The drug should not be used in pregnancy and should be prescribed with caution during lactation. There is no data about the excretion of almotriptan in human milk but infant exposure could be minimised by avoiding breast-feeding for 24 hours after treatment.

Most common side-effects include fatigue, nausea and vomiting, dizziness and somnolence and, less frequently, chest pain and tightness which may involve the throat.

Basic NHS prices are £9.75 for three, £19.50 for six and £29.25 for nine tablets.

Lundbeck Ltd.
Tel: 01908 649966.

IN BRIEF

Meningitis vaccine from SKB

SmithKline Beecham Vaccines ore introducing o new meningitis voccine effective against meningacaccal meningitis A, C, W135 ond Y. Lost yeor over 50 peaple were affected by an autbreok of meningitis type W135 following o pilgrimoge to Mecco. The vaccine, called 'ACWY Vax', is recammended by the Deportment of Healtb far trovellers at risk.

GloxoSmithKline.
Tel: 01707 325111.

Coloplast adds to Assura range

Fram February 1 there will be an additionol 24 cades within the Assuro: Inspire Closed/Droinable 1 Piece ronge available on FP10.

Coloplast Ltd.
Tel: 01733 392009.

Clinutren Fruit from Nestlé

Nestle Clinical Nutrition has intraduced Clinutren Fruit. The supplement has 1.25kcal/ml and 4g of protein per 100ml. Clinutren Fruit is avoilable in a 200ml cup in four different flovours: Rospberry-Blackcurrant, Grapefruit, Orange and Peor-Cherry. The supplement hos ACBS opproval.

Nestlé Clinicol Nutrition.
Tel: 020 8667 5130.

New Aerochamber range

3M's AeraChamber range will be replaced with AeroChamber Plus when stocks of the current models ore exhausted. Patients will use the ronge in exactly the same way and product codes and prices remain unchanged.

3M Health Care Ltd.
Tel: 01509 613228.

Licensed valproate for bipolar disorder

Sanofi Synthelabo is launching Depakote (valproate semi-sodium) for the acute treatment of a manic episode associated with bipolar disorder.

Valproate semi-sodium is a compound comprised of sodium valproate and valproic acid in a one to one molar relationship. It has been available in the US as divalproex sodium.

To ensure the correct medication is supplied for the patient's condition, care must be taken not to confuse Depakote with Epilim or sodium valproate. The patient information leaflet will clearly indicate the specific indication for Depakote.

The recommended starting dose for adults is 750mg daily in two or three divided doses. This should then be increased as rapidly as possible to give the desired clinical effect with the lowest therapeutic dose. Daily doses are usually in the range 1,000mg to 2,000mg.

Basic NHS prices for a blister pack of 90 tablets are £43.19 for 250mg and £72.19 for 500mg.

Contraindications and warnings are as for other valproate products. Further information and a full Summary of Product Characteristics is available from the company.

Sanofi Synthelabo.
Tel: 01483 505515.

Triple HIV therapy in one tablet

GlaxoSmithKline has launched Trizivir for the treatment of HIV infected adults. Each tablet contains three nucleoside reverse transcriptase inhibitors (NRTIs): zidovudine 300mg, lamivudine 150mg and abacavir 300mg.

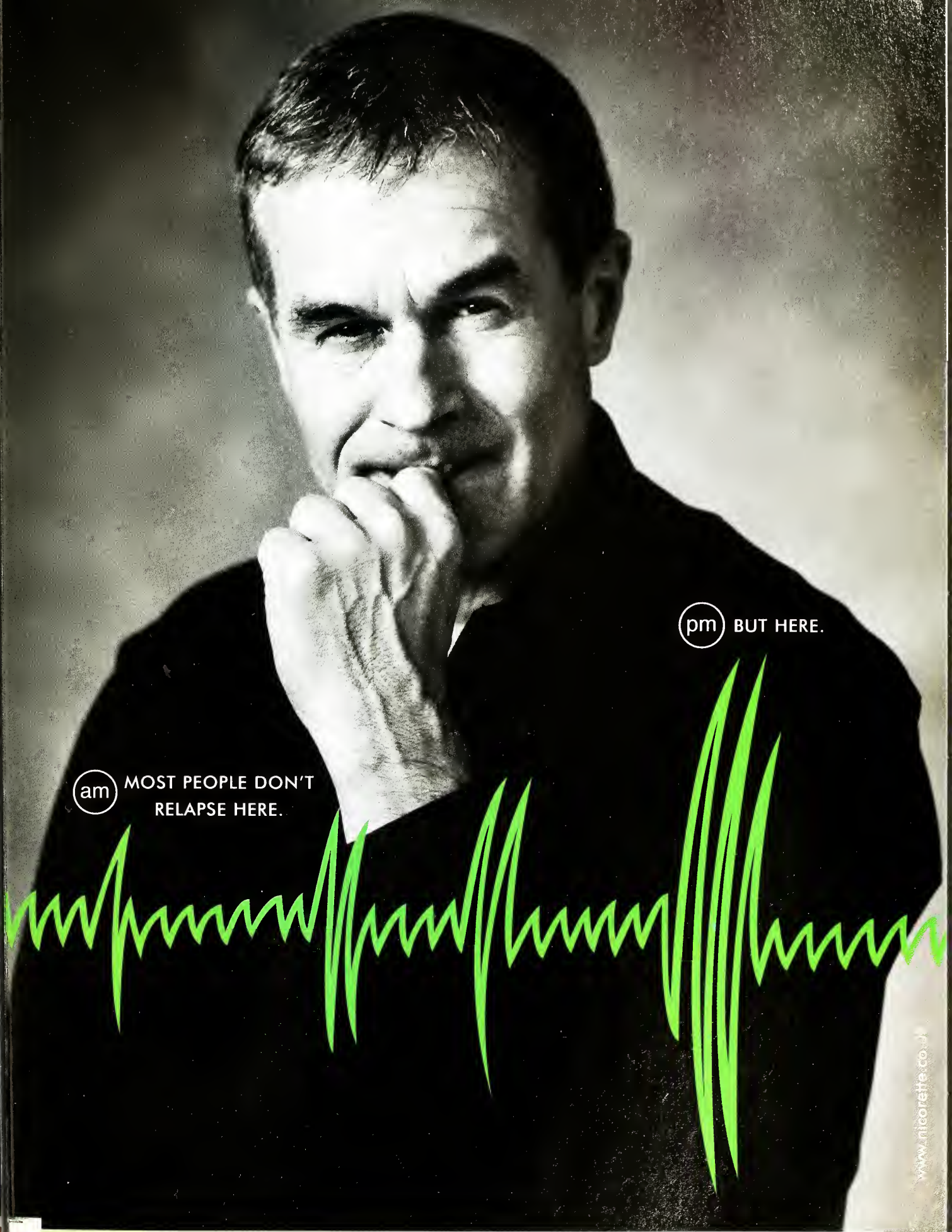
The adult dose is one tablet twice daily. It is recommended that the three component drugs are given separately for the first six to eight weeks due to potential hypersensitivity reactions to abacavir. By simplifying the dosage regime to one tablet twice daily long-term adherence and therefore efficacy should be improved.

Trizivir is contraindicated in severe hepatic impairment, end-stage renal disease, abnormally low neutrophil count or haemoglobin level or in those hypersensitive to any of the ingredients. About 4 per cent of patients receiving abacavir experience hypersensitivity reactions which can be life-threatening. Abacavir must never be restarted in patients who have previously stopped therapy due to a hypersensitivity reaction.

The drug should not be co-administered with IV ganciclovir, foscarnet or high doses of co-trimoxazole. The most commonly reported adverse events include nausea, vomiting, fatigue, fever and headache.

Basic NHS price is £581.08 for 60 tablets.

GlaxoSmithKline.
Tel: 020 8990 9000.



Studies show smokers are most likely to relapse around tea-time rather than early morning.[1] And as the day wears on this is when smokers need help most. Nicorette is the patch specifically designed to work for 16 hours. It not only keeps strong tea-time cravings under control but leaves smokers nicotine-free at night, so there's less chance of sleep disturbance.[2] When regular smokers need continuous craving relief recommend Nicorette 16 hour patch.

NICORETTE®
contains nicotine
16 hour Patch
CONTINUOUS RELIEF WHEN THEY NEED IT MOST

Counterpoints

A real eye-opener from L'Oréal

L'Oréal is launching a retinol treatment to help smooth away the appearance of lines and wrinkles around the eyes.

L'Oréal Plenitude Line Eraser Eyes has been developed to offer the benefits of retinol in a cream that is gentle enough for use around the delicate eye area.

The product contains concentrated retinol and is quickly absorbed to nourish the skin.

L'Oréal claims its tests show that the appearance of fine lines around the eyes is significantly reduced after two weeks of daily application.

Suitable for use on sensitive skin and by contact lens wearers, the product has been dermatologically and ophthalmologically tested. It will be available from February.

Retail price is £8.99.

L'Oréal Group UK.
Tel: 020 8762 4000.

Brush up on pester power!

Stafford Miller is launching a Sensodyne range of Pokémon toothbrushes for children.

Developed in association with Nintendo, the range is designed to maximise on the Pokémon craze among children.

The range includes four toothbrushes featuring Pokémon characters Squirtle, Psyduck, Poliwhirl and Mewtwo.

All the toothbrushes have a chunky junior handle designed to be easy for children to grip. Other features include a compact brush head and slim neck for easy access to all areas of the mouth.

The bright packaging features the young Pokémon trainer Ash.

A colourful range of merchandising material includes Pokémon stickers, a poster and display unit.

Retail price is £1.99.

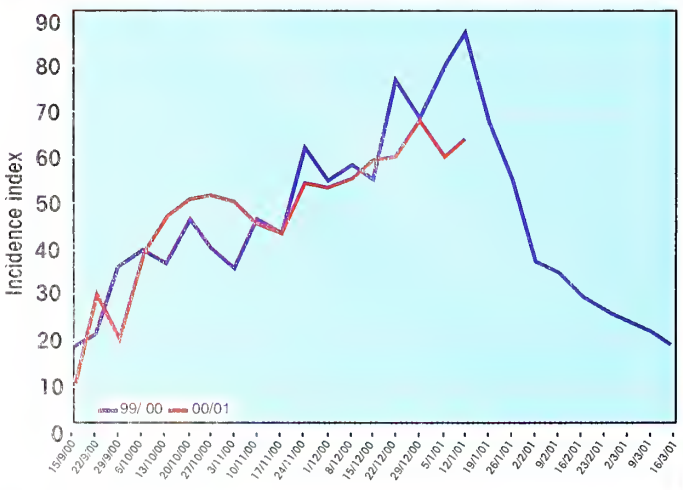
Stafford-Miller Ltd.
Tel: 01707 331001.

Cough, cold & flu FORECAST

Information updated weekly by SDI

SPONSORED BY Benylin

United Kingdom	Status level	Number of weeks on status	Season 2000/2001 projected population affected by respiratory illness	2000/2001 vs. 1999/2000 cumulative season-to-date % difference
BIRMINGHAM	Alert	5 weeks	188,858	-7.54%
BRISTOL	Alert	4 weeks	37,295	3.26%
GLASGOW	Alert	4 weeks	50,349	-33.41%
LEEDS	Alert	5 weeks	201,569	5.46%
LONDON	Alert	3 weeks	921,280	-12.46%
MANCHESTER	Alert	4 weeks	271,959	-7.00%
NEWCASTLE	Alert	5 weeks	38,168	-10.77%
NORWICH	Alert	4 weeks	13,990	-9.61%



A launch with a light touch from Revlon

Revlon will be launching a light-reflecting cosmetics range in the UK in May. Skinlights Face Illuminators has already been introduced in the US and in Australia.

Targeted at women aged 18-35, the range will include five coloured lotions, sticks and powders.

The products are formulated with natural minerals that reflect light and add colour to skin tones. Retail prices will start from around £9.00.

A TV advertising campaign will support the launch.

Revlon International Corp.
Tel: 020 7629 7400.

Handwashing is child's play with Carex

Cussons is relaunching its Carex for Kids Antibacterial Handwash with bright, new packaging, incorporating the updated brand identity.

Suitable for all skin types, the mild product contains the Dermaclens antibacterial moisturising system to help protect hands from germs.

A major advertising campaign for the Carex range is planned for this year.

Cussons (UK) Ltd.
Tel: 0161 491 8000.

Aquafresh hits the campaign trail

GlaxoSmithKline Consumer Healthcare is supporting its Aquafresh Multi-Active toothpaste with a £2.4 million TV campaign until early March.

The commercial features a mum struggling to ensure her family are ready to leave home on time – safe in the knowledge that their teeth are being taken care of. The campaign highlights the anti-bacterial action of Aquafresh Multi-Active toothpaste.

From February 1, the commercial will feature the Aquafresh Max Active toothbrush, especially the X-Active.

GlaxoSmithKline Consumer Healthcare.
Tel: 020 8560 5151.

Reach for the best

Established in 1938 to meet the needs of retail pharmacists, BCM Specials is now the premier Specials supplier in the UK.
We are the best because we hold true to our founding principles, namely to supply quality Specials in the shortest possible time.

With its unrivalled range of formulae and its 'state of the art' facilities there is little BCM Specials cannot provide.
To meet your need for quality, range, speed of service and flexibility BCM Specials is the best option.

BCM Specials putting your patient first.

www.bcm-specials.co.uk

Gillette makes retailing a site better

Gillette is launching a new category management web site for independent retailers this week.

The web site is designed to assist independent and small multiple retailers in maximising display impact, sales potential and profitability.

Registered retailers are guided through areas such as correct siting, product stocking, new product launches and displays.

There is an opportunity to view the entire interior of a West Midlands pharmacy and zoom in on any section.

The web site will be constantly updated with latest market data and product performance information for male and female grooming, oral care, batteries, and household and personal diagnostic categories.

From late spring, pharmacists will be able to key in their postcode to access a demographic profile for their pharmacy. This will be linked into 'optimised assortment' to provide the recommended range to fit an individual pharmacy profile.

Simon Smith, group category manager for Gillette, says: "This is an opportunity to give independent pharmacies access to the same sort of tools that are used by larger retailers."

Pharmacies can register free online at *www.catmanonline.uk.gillette.com*

Gillette Group UK Ltd.
Tel: 020 8560 1234.

Lactacyd adds intimate care to the curriculum

GlaxoSmithKline Consumer Healthcare is supporting its Lactacyd Femina range with an educational campaign through pharmacies.

Educational material and product samples are available from the GSK salesforce while stocks last.

A new leaflet explains why lactic acid is important and how the pH balance can be disturbed by factors such as sex, periods, soap and tight clothing.

The leaflet also features a competition with prizes of luxury health spa treatments for three winners.

Discreet credit card-sized information cards are also available to pass on to customers.

The pharmacy drive will be followed by a national press campaign for Lactacyd Femina scheduled for spring.

GlaxoSmithKline Consumer Healthcare.
Tel: 020 8560 5151.

IN BRIEF

Herbal leaflets

Herbal Concepts is launching two leaflets on how herbal medicines can help women's health and weight loss. These are available free to pharmacies to give away at point of sale. The company's web site *www.herbal-concepts.co.uk* includes information on the Herbal Concepts range.

Herbal Concepts Ltd.
Tel: 01296 689045.

Kamillosan change

Kamillosan Ointment is now only available as a 50g pack. The 30g pack has been discontinued.

Ceuta Healthcare.
Tel: 01202 780558.

Crowning glory

Paul Murray plans to relaunch its Head Girl hair accessories and jewellery range.

Head Girl products will be presented on eye-catching purple stardust polypropylene plastic from April.

The jewellery will appear on opaque purple and silver packaging, while the hair products will have opaque purple display cards. Retail prices range from £0.49 - £9.99.

Paul Murray plc.
Tel: 023 8026 8444.

Olbas campaign aims to settle the congestion question

Lanes is supporting its Olbas decongestant with a £1.3 million advertising campaign to coincide with the peak season for coughs and colds.

The 'Power to Breathe' TV ad is appearing on Channel 5 until the end of February. Launched last year, it features an animated wheezing balloon to convey the discomfort of congestion, which is relieved when an Olbas Inhaler stick bursts the balloon.

Press advertising will appear in national newspapers until the end of March. There are four executions - one each for Olbas Oil and Olbas Pastilles, and two for the Olbas Inhaler Stick.

Eye-catching PoS material includes showcards, range display trays, inhaler display trays and oil display trays.

GR Lane Health Products Ltd.
Tel: 01452 524012.

ON TV NEXT WEEK

Aquafresh toothpaste: All areas except U
Beechams: U
Beechams winter remedies: All areas except U, CTV
Benylin: All areas
Breathe Right nasal strips: All areas except C4, Sat
Covonia: U, C, A, HTV, W, M, GMTV
Day/Night Nurse: All areas except U, CTV
Lemsip: All areas except CTV
Nicorette: All areas
Niquitin CQ: All areas except U,CTV
Niquitin CQ clear: U
Olbas: C5
Senokot: All areas
Sensodyne toothpaste: All areas
Seven Seas Pure Cod Liver Oil: B, G, Y, A, W, LWT, TT, C4
Sudafed: All areas except GMTV
Pharmasite for next week: Nicorette Patch – Window. **Nicorette Gum** – In-store. **Nicorette Inhalator** – Dispensary

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Seven Seas to get the joints jumping

Seven Seas is supporting its Pure Cod Liver Oil with a national advertising campaign until March.

The 'twist' commercial, which was first screened in autumn 2000, will be on TV again throughout February and into March.

Aimed at new, younger consumers, the campaign focuses on the benefits of cod liver oil for natural relief of joint pains and stiffness.

Set in various locations, the commercial features a large cast of people taking part in a variety of healthy and sporting activities to the soundtrack of 'Let's Twist Again'.

The campaign also includes advertising on the back of buses and in national daily newspapers.

Seven Seas Ltd.
Tel: 01482 375234.

All over Britain people are catching colds.

(Great news!)

Stock up now with Halls Mentho-Lyptus. Then take a deep breath!

- **EXTRA HEAVY DEMAND**, due to the coughs and colds season and national consumer advertising.
- **5 GREAT FLAVOURS** – Original, Blackcurrant, Original Sugar Free, Cherry Sugar Free and the best selling Extra Strong.
- **THE 'MUST HAVE' MEDICATED CONFECTIONERY BRAND.**
- **BRAND NEW**, topical and impactful 'Take a deep breath' national advertising campaign.

So display well and get ready for the rush!

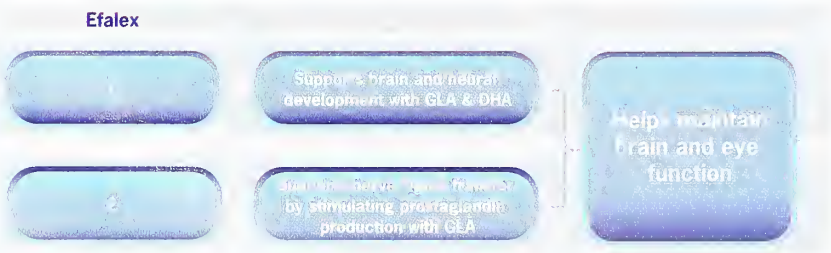
Another great brand from Adams.

ADAMS

Profit from our experience

The first multi-action supplement range from Nutricia

Introducing a new, multi-action approach to help maintain a healthy body through nutritional support and supplementation. Developed by nutritional experts, the Nutricia range is designed to help maintain good health at different life stages. Every nutrient is supported by published evidence. Each product has two or more ways of working. For example:-



The range includes supplements to help maintain healthy bones, healthy heart, healthy eyes, hormonal balance, iron intake and brain function. We also offer multivitamin supplements for men's and women's health, pregnant and breast feeding women, and an antioxidant formula.

The Nutricia range is backed by a £1 million spend on consumer and trade advertising, targeted mailings and POS. We will also be instigating a specific educational programme to Healthcare Professionals to raise awareness of the benefits of supplementation. Nutricia. No-one is more serious about nutritional support.

NUTRICIA SUPPLEMENTS
The science of well-being

PHARMACYupdate

The Royal College of Physicians has recently produced guidelines on stroke. Dr Pippa Medcalf explains how pharmacists fit into these guidelines

Striving to stop strokes

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1189), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* FEBRUARY 10, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To appreciate the incidence of stroke and its consequences for health care
- To ta be aware of the latest clinical guidelines an stroke
- To recognise the key risk factors for strake
- Ta understand the role pharmacists can play in the secandary prevention of stroke
- To be able to advise patients on medicatian and lifestyle issues

Stroke is the UK's third most common killer after heart disease and cancer, claiming a life every 15 minutes. It is the largest single cause of major disability and costs the country over £2 billion per year.

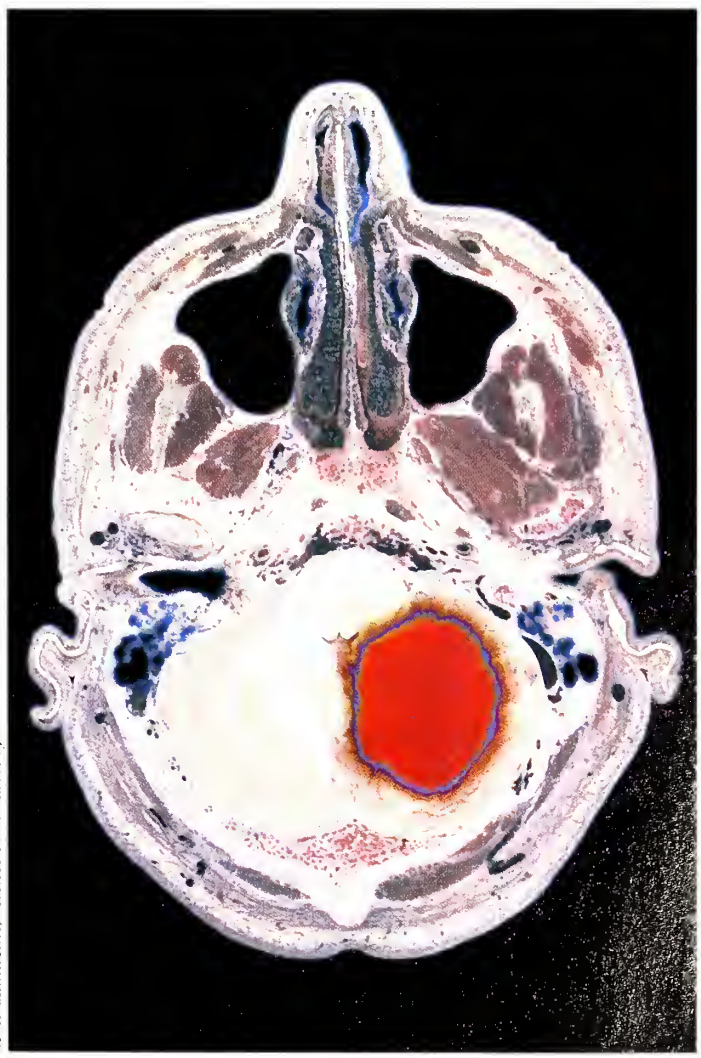
Patients with stroke-related illness occupy about 16,000 hospital beds each day (around 13 per cent of occupied beds in the NHS). A quarter of all nursing home beds are occupied by stroke patients still in institutional care a year after stroke.

Even ten years ago, stroke was was estimated to result in the loss of almost 8 million working days per annum in the UK with a loss to the economy of around £445 million. This has led to a major drive to prevent this health problem.

New guidelines recommend management strategies that may be particularly important for patients who have already had a transient ischaemic attack (TIA) or stroke, as these people are about 13-15 times more likely to have a stroke than the general population in the first year after their initial event.

Secondary prevention of stroke is often neglected. A Stroke Association survey showed that most patients thought there was little they could do to prevent further strokes. Many were not taking aspirin even though it was indicated and some with high blood pressure were not on antihypertensive medication.

Pharmacists can help support their stroke patients, directly or through their carers, by advising, where oppropriate, about the importance of secondary preventative measures and compliance with them, for example, lifestyle changes, taking appropriate antiplatelet/ antihypertensive/cholesterol-lowering medication.



Scott Camazine/Science Photo Library

Haemorrhage: an area af internal bleeding (calaured red) in the cerebellum af the brain. The bleeding has led ta a strake

About strokes

A stroke is a disruption in the supply of blood to

Continued on PII →

Continued from P1

the brain, causing permanent damage. Most strokes are ischaemic, caused by clots which have formed in a brain artery or travelled to it (cerebral thrombosis or embolism, respectively). Ischaemic impairment due to damage to small cerebral blood vessels in the brain is called a lacunar stroke.

About 15 per cent of strokes are caused by bleeding in or around the brain – haemorrhagic strokes. An intro-cerebral haemorrhage involves bleeding within the brain and a subarachnoid haemorrhage occurs in the space surrounding the brain. The cause of stroke is uncertain in around 5 per cent of cases.

Symptoms

Individuals may be affected by stroke quite differently. Key factors are which part of the brain has been affected and the extent of damage to brain cells. However, the most common symptoms are listed in table 1.

In a TIA a patient makes a full recovery within 24 hours but stands a high risk of further stroke.

Patients with stroke or suspected stroke should be admitted to hospital for a computed tomography (CT) scan to exclude haemorrhagic stroke. Antiplatelet therapy, a key part of secondary prevention in other cases, is contraindicated in patients with haemorrhagic stroke.

Key risk factors for stroke are listed in table 2.

Previous stroke or TIA

As mentioned previously, patients who have already suffered a stroke or TIA face a higher risk of having another stroke and other vascular events.

New guidelines published by the Royal College of Physicians of London (*www.rcplondon.ac.uk*) – 'National Clinical Guidelines for Stroke' – say that because of this, a high priority should be given to preventing a second stroke (secondary prevention). The Guidelines were prepared by the Intercollegiate Working Party for Stroke and are founded on evidence-based practice.

The section on secondary prevention applies to all patients, even those not admitted to hospital. It thus refers to patients either before discharge from hospital or within four weeks of stroke onset, whichever is soonest.

For secondary prevention the RCP guidelines advises the following:

- All patients should have their blood pressure checked and hypertension persisting for over one month should be treated. (The treatment target is <140/85mmHg, with a minimum level of control of <150/90mmHg).
- All patients not on anticoagulation should be taking aspirin (50-300mg) daily, or a combination of low-dose aspirin and dipyridamole modified release (MR). Where patients are aspirin-intolerant, an alternative antiplatelet agent (clopidogrel 75mg daily or dipyridamole MR 200mg twice daily) should be used.
- Anticoagulation should be started in every patient in atrial fibrillation (valvular or non-valvular) unless contraindicated.
- Anticoagulation should be considered for all patients who have ischaemic stroke associated with mitral valve disease, prosthetic heart valves, or within three months of myocardial infarction.

Table 1: Common stroke symptoms

- Numbness, weakness or paralysis, to the whole or part of one side of the body
- Loss of awareness of affected limbs
- Confused, or loss of, speech
- Difficulties in understanding
- Difficulties in reading and writing
- Problems in remembering
- Loss of concentration
- Fatigue
- Difficulties in swallowing
- Disturbed vision
- Incontinence

Table 2: Key risk factors for stroke

- Previous stroke or TIA
- High blood pressure
- Heart disease (abnormal heart rhythm or heart valve abnormality)
- Diabetes
- Smoking
- High alcohol intake
- Overweight
- Lack of exercise
- High cholesterol levels
- High salt intake

Tackling these risk factors should reduce the substantial mortality and morbidity associated with stroke

High blood pressure is a key risk factor for stroke and the treatment target should be 140/85mmHg

- Anticoagulation should not be started until brain imaging has excluded haemorrhage and 14 days have passed from the onset of ischaemic stroke.
- Anticoagulation should not be used after transient ischaemic attacks or minor strokes unless cardiac embolism is suspected.
- All patients should be given advice on lifestyle factors (see later).
- Therapy with a statin should be considered for all patients with a past history of myocardial infarction and a cholesterol level >5.0mmol/L following stroke.

The RCP Guidelines do not specify a target International Normalised Ratio (INR) to monitor anticoagulation. However, this issue was dealt with recently in another set of guidelines from a group with a special interest in secondary stroke prevention – the ASSET group (Actions for Secondary Stroke Prevention Education and Training).

The ASSET guidelines recommend a target INR of 2.5 for patients with atrial fibrillation. They add that, when compared with placebo, one vascular event will be prevented in one year for every 11 patients with atrial fibrillation treated with warfarin. Antiplatelet therapy may be of use to those

Continued on P1V→

escribing information
ease refer to the full
C before prescribing)
ban 150 mg
olonged-release tablets
upropion HCl)

Smoking cessation (with motivational ort) in nicotine-dependent patients. **ge and administration** *Adults from eors:* Start treatment while still king and set 'target stop date' within wo weeks. 150 mg o.d. for 3 days then mg b.d. for remainder of 7 to 9 week se. Maximum 150 mg single dose and mg daily. Allow at least 8 hours ween doses. Review at week 7; ntinue if no effect. *Elderly, renal or to-moderate hepotic impairment:* mg o.d. **Contra-indications** Hyper-tivity, previous/current seizure or g disorder, recent/current MAOIs, re hepatic cirrhosis, bipolar disorder. **autions** Predisposition to lowered ure threshold/increased risk of res (including previous head injury, tumour, other medications, alcohol e, diabetes), renal or mild-to-erate hepatic impairment, elderly, eptibility to psychotic episodes. **Drug ractions** Theophylline, tricyclics, SSRIs, ls, antipyschotics, beta-blockers, 1c antiarrhythmics, enzyme inducers/ tors, orphenadrine, cyclophosphamide, lopa. **Pregnancy and lactation** Not mmended. **Side effects** *Common:* mouth, gastrointestinal pain/upset, nnia, tremor, concentration disturbance, ache, dizziness, depression, agitation, ty, rash, pruritus, urticaria, sweating, taste disorders. *Uncommon:* chest asthenia, tachycardia, blood pressure ges, flushing, confusion, anorexia, us, visual disturbance. *Rare:* vasodilation, ope, seizures, severe hypersensitivity ions including anaphylaxis, arthralgia, gia and fever, erythema multiforme, ens Johnson syndrome. **Presentation Basic NHS cost** 60 tablets £42.85. **uct Licence (PL) no.** PL10949/0340. **holder** Glaxo Wellcome UK Ltd., dley Park West, Uxbridge, UB11 1BT. 1

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rry LH. Primary Care Clinics in Office actice 1999; **26**: 653-669.
wey LS, Sullivan MA, Johnston JA, *et al.* ugs 2000; **59**: 17-31.
renby DE, Leischow SJ, Nides MA, *et al.* Engl J Med 1999; **340**: 685-691.

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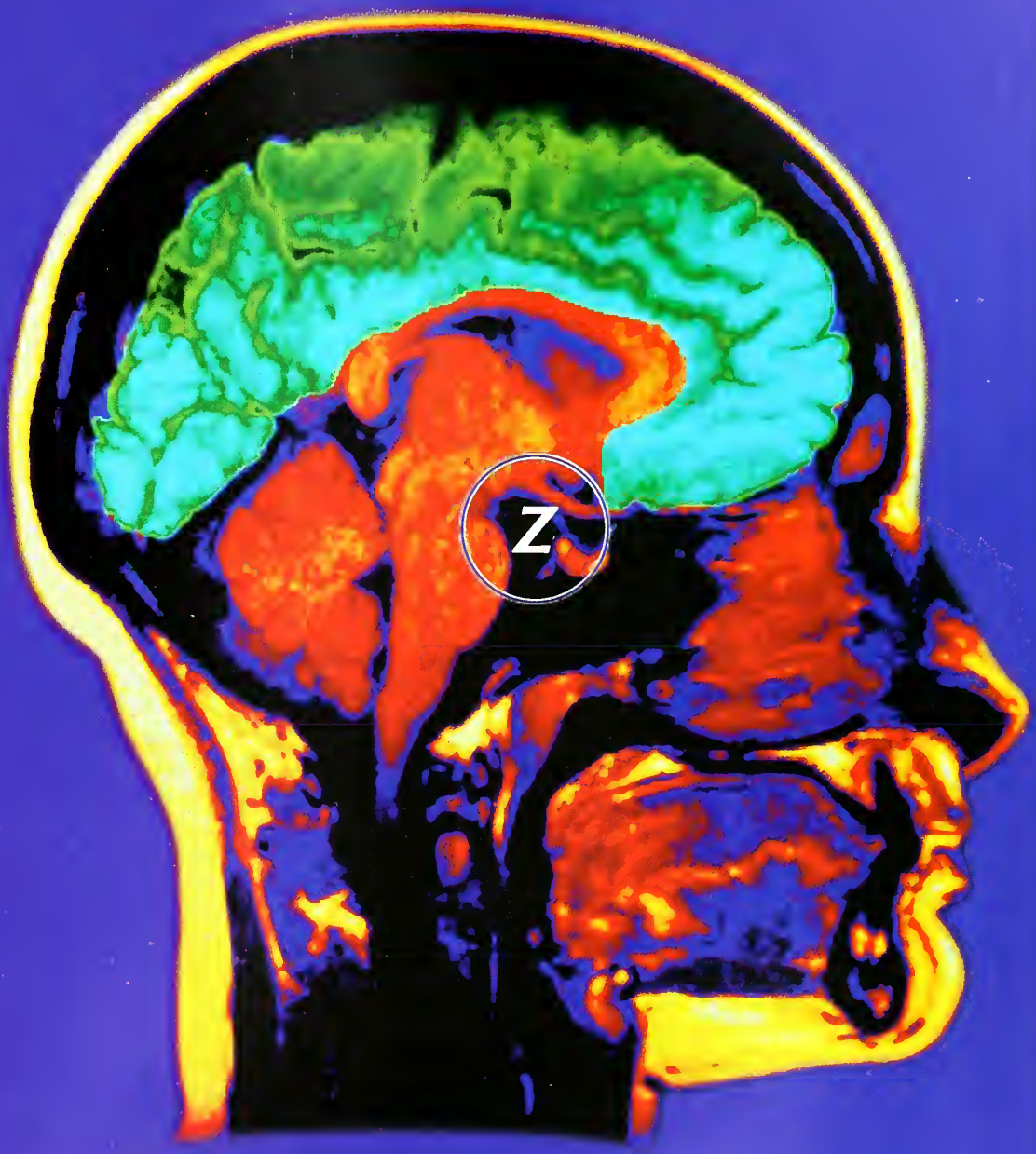
FOR SMOKING CESSATION
Z MARKS THE SPOT



Nicotine addiction is a neurobiologically-mediated brain disease.[1] Zyban is a unique non-nicotine tablet therapy that works in the brain by acting on the neurotransmitters involved in nicotine addiction and withdrawal.[2,3] In a trial published in The New England Journal of Medicine, Zyban was shown to be almost twice as effective as a nicotine patch in achieving smoking abstinence at one year.[4]

NEW
Zyban
bupropion HCl SR
Science against smoking

26439/B - June 2000

Continued from PII

patients where warfarin use is felt to be inadvisable due to bleeding risk.

Evidence for the treatment used

Aspirin and dipyridamole – The second European Stroke Prevention Study (ESPS 2) showed that aspirin (50mg daily) reduced the risk of secondary stroke by 18.1 per cent compared with placebo. The same trial found a risk reduction of 16.3 per cent compared with placebo for dipyridamole MR 200mg twice daily.

However, when dipyridamole MR was combined with low dose aspirin, the reduction in risk of secondary stroke was more than double that of monotherapy – a risk reduction of 37.0 per cent compared with placebo.

In terms of 'numbers needed to treat' (NNT), one stroke will be prevented in two years for every 38 patients treated with aspirin compared with placebo, and for every 18 patients treated with aspirin plus dipyridamole (MR).

Clopidogrel – The CAPRIE (clopidogrel versus aspirin in patients at risk of ischaemic events) study showed an 8.7 per cent relative risk reduction with clopidogrel versus aspirin in preventing the composite endpoint of ischaemic stroke, myocardial infarction or vascular death. This equates to an NNT over 1.91 years of one vascular event prevented for every 115 patients treated with clopidogrel rather than aspirin.

Ticlopidine is also licensed for the reduction of risk of recurrent stroke. However, this agent has been associated with haematological adverse effects including severe neutropenia and should be initiated by a clinician in hospital.

Aspirin has an important role in reducing the risk of secondary stroke

How they work

Aspirin's antiplatelet effects are due to its irreversible inhibition of cyclo-oxygenase in platelets. This prevents platelet aggregation caused by the cyclo-oxygenase product thromboxane A2.

Dipyridamole's antithrombotic effects are largely due to its inhibition of adenosine uptake and inhibition of cyclic guanoside monophosphate phosphodiesterase.

Clopidogrel and ticlopidine inhibit the binding of adenosine diphosphate to its platelet receptor and the subsequent ADP-mediated activation of the GPIIb/IIIa complex, thereby inhibiting platelet aggregation.

ACTION PLAN

1. In your practice workbook carefully define the difference between the terms 'transient ischaemic attack (TIA)' and 'stroke'
2. Search the literature to find the optimum dose of aspirin to be used to prevent a TIA or stroke. Do many of your patients take low dose aspirin? Do you initiate such treatment? Should you?
3. In your practice workbook develop a list of lifestyle proposals to make to patients who have had a TIA. Does this differ from the advice you would give to any patient?
4. As hypertension is frequently asymptomatic, how would you persuade a patient who has had a TIA and suffers with the elevated blood pressure to continue 'taking the tablets'?
5. In your practice workbook construct a table of drugs used to reduce the likelihood of a TIA or stroke. Note the doses and their side effects so that you can easily identify potential problems for patients initiated on such regimes.
6. Try to find out the relative benefits and potential drawbacks of normal and enteric coated aspirin.

Hypertension

High blood pressure is one of the greatest risk factors for stroke. It is believed to be a factor in nearly 70 per cent of strokes. It is vital for patients who have had a stroke to have their blood pressure checked regularly and normalised, aiming for a blood pressure <140/85 mmHg – often with drug therapy. Patients are also advised to adopt a low salt diet and other lifestyle changes to reduce blood pressure.

Surgery

In a group of patients whose strokes have been caused by a narrowing of an artery in the neck, unblocking the vessel in a procedure known as carotid endarterectomy is indicated. Further recommendations on this are given in the RCP Guidelines.

Pharmacists' support

Pharmacists and other healthcare professionals are well placed to help emphasise lifestyle measures to reduce the risk of further strokes. These include giving up smoking, keeping alcohol intake within moderate limits, taking regular exercise, reducing fat intake and losing weight where appropriate.

Pharmacists can help advise patients on the role of their medication and also provide useful information on products that may help improve compliance. For example, a common side effect that may occur on starting dipyridamole is headache. However, the headache is usually transient, with the patient developing rapid tolerance within the first week.

Compliance could be increased by warning patients that they could experience headache, but should persist with their medication if possible. Patients can be advised to take paracetamol for their headache if needed, but taking additional, over-the-counter aspirin should be avoided.

Some stroke sufferers face severe disability, losing the ability to walk and talk, even to understand. Patients may require long-term care in residential or nursing homes. Many will embark on rehabilitation.

Luckier patients will have escaped the loss of faculties. Either way, pharmacists can help ensure that appropriate measures are in place to give these patients the best chance of avoiding another stroke.

Dr Pippa Medcalf is a consultant physician at the Royal Hospital in Chesterfield

References available on request

C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001

Further help from:

The Stroke Association
Stroke House
123-27 Whitecross Street
London EC1Y 8JJ
Tel: 020 7566 0300
www.strake.org.uk

Chest Heart and Stroke Scotland
65 North Castle Street
Edinburgh EH2 3LT
Tel: 0131 2256963/
0845 077 6000
www.chss.org.uk

Different Strokes
162 High Street
Watford, Herts WD1 2EG
Tel: 01923 240615
www.differentstrokes.co.uk

PHARMACYupdate: distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the February 10 issue, which will cover this week's CPP-accredited modules, together with those in the January 6 issue.

In other words:

- Cystic fibrosis (1187)
- Probiotics (1188)
- Strokes (1189).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

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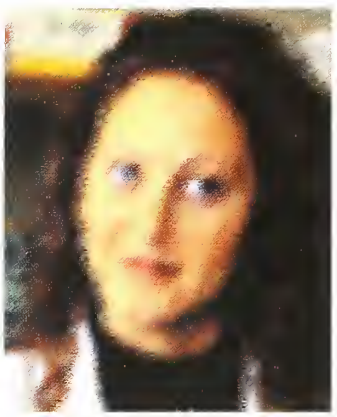
GENUS PHARMACEUTICALS

A complicated condition

Patients with diabetes often suffer concurrent medical conditions and diabetic complications. Mary Allen uses a case study to explain some of the issues around diabetes



Mr Butler is a regular customer in Jill's pharmacy. He is 69 years old and suffers from diabetes and cardiovascular disease. He is highly intelligent and usually puts Jill through her paces when he comes to collect his medicines, asking informed questions about the latest treatments.

The medicines

Mr Butler's current PMR reads as follows:

Insulatard human insulin	*100iu 3ml cartridges, as directed*
Glucotrend Plus blood glucose reagent strips	
Candesartan	*16mg, one daily*
Warfarin	*3mg and 1mg, as directed*
Softclix II lancets, Novofine needles	
Metformin tabs	*500mg, one bd*
Digoxin	*125 mcg, three daily*

What type of diabetes does Mr Butler have?

At first glance, it looks as though Mr Butler is suffering from type 1 diabetes, since he is an insulin user. But in fact, he is a type 2 diabetic patient.

From his PMR history, Jill can see that Mr Butler is taking Metformin but has only been prescribed insulin within the last year or so. Previously he had been taking gliclazide and a sulphonylurea in addition to metformin.

In addition to his insulin and metformin, Mr Butler is also taking digoxin, warfarin and candesartan. The combination of digoxin and warfarin suggests that Mr Butler is probably suffering from atrial fibrillation (AF).

1. Digoxin is commonly used to control ventricular rate in AF by depressing conduction in the heart. Following a loading dose, the usual maintenance dose range is 125-375mcg daily, according to renal function, body mass index, concomitant drugs and the patient's age. It has a narrow therapeutic margin.

Adverse drug reactions (ADRs) include anorexia, nausea, vomiting, diarrhoea, bradycardia, confusion and arrhythmias. Unwanted effects depend on the plasma concentration of digoxin and (for cardiac side effects) on the sensitivity of the myocardium, which is often increased in heart disease.

The risk of toxicity increases progressively as plasma levels increase from 1.5 to 3 mcg/litre. Plasma levels should be checked, particularly where side effects are suspected.

Mr Butler is on a high dose (375mcg) but is not a frail old man. Jill has questioned the dose before and learned that his digoxin levels are monitored regularly, and he does not appear to be suffering from any of the side effects associated with digoxin toxicity.

2. Warfarin is an anticoagulant that inhibits the production of coagulation factors by interfering with the actions of Vitamin K. AF is associated with an increased risk of stroke and thromboembolism.

Recent large, randomised controlled trials looking at stroke prevention in AF have indicated that warfarin is associated with a 64 per cent risk reduction. Warfarin therapy requires regular dose intervals and frequent INR monitoring. INR measurement gives an indication of prothrombin time through reference to an international standard.

The current recommended target INR is 2.5 in AF management. Plasma warfarin levels are affected by:

- other drugs (enhanced by amiodarone)
- alcohol, especially binge, or irregular, drinking
- general health eg affected by colds, etc
- diet, particularly foods containing Vitamin K and garlic.

3. Candesartan is a specific angiotensin II receptor antagonist, inhibiting the final stage of the renin-angiotensin-aldosterone pathway. Its action is more specific than that of the ACE inhibitors, which inhibit the conversion of angiotensin I to angiotensin II (ie they act on earlier stage in the pathway). But the effect is the same – a reduction in vasoconstriction and aldosterone release, resulting in a control of blood pressure. Mr Butler's dose is high and, because of his age, Jill might wish to query this with the prescribing doctor.

Mr Butler had previously taken lisinopril (an ACE inhibitor) but had suffered from a persistent dry cough. This side effect occurs in up to 20 per cent of patients taking ACE inhibitors. It is thought to be due to increased levels of bradykinin, which is normally broken down by ACE.

The side effect is thought not to occur with angiotensin II receptor antagonists because they act at a different site. However, there is some evidence to suggest that cough is not always avoided with this new class of antihypertensive.

While Mr Butler's lisinopril had originally been prescribed for hypertension, ACE inhibitors have also been found to be protective in diabetic nephropathy. In any case, blood pressure should be well controlled in people with diabetes to minimise the risk of renal deterioration.

What about his diabetes medication?

At an earlier stage in his illness, Mr Butler had taken gliclazide and metformin, but is now taking metformin and injecting insulin, and is fairly well controlled.

1. Gliclazide is a sulphonylurea. Drugs in this group are thought to stimulate insulin secretion from the pancreatic beta cells. They are often used in non-obese patients where the main problem is thought to be associated with impaired insulin secretion. An unwanted side effect is weight gain.

Long-acting sulphonylureas may leave older people vulnerable to hypoglycaemia. The very long-acting chlorpropamide is little used today. Glibenclamide is also fairly long acting and should be avoided in the elderly. The shorter-acting gliclazide or tolbutamide are preferred. These drugs are also preferable in patients with renal impairment.

Around a third of patients will fail to reach glycaemic targets with sulphanylureas, with a further ten per cent subsequently failing to reach targets each year, probably due to disease progression.

2. Metformin inhibits glucose production in the liver, and increases the peripheral utilisation of glucose. Unlike the sulphanylureas, it has no effect on insulin secretion and is not associated with hypoglycaemia or weight gain.

Metformin is recommended as a first-line drug in diet-treated overweight patients. Its main side effects are gastro-intestinal, particularly diarrhoea and heartburn.

Starting slowly (one tablet daily) and building up gradually helps to reduce initial GI side-effects, and taking tablets after a meal may also help. Metformin can be used as mono-therapy or in conjunction with a sulphanylurea.

Metformin should not be used in renal impairment as it can provoke lactic acidosis. Care is needed in patients with severe dehydration, infection, shock, severe heart failure, myocardial infarction, hepatic impairment or alcohol dependency.

3. Insulin is indicated for patients inadequately controlled by diet, exercise and/or oral drugs (and in pregnancy). It may be used in combination with a sulphanylurea and/or metformin. Between 10 and 20 per cent of type 2 diabetic patients are thought to use insulin.

Insulin therapy may be required temporarily if patients suffer from other illnesses including:

- myocardial infarction
- infection
- trauma
- surgery.

Mr Butler believes that he might benefit from an additional injection of short-acting insulin. Is this the case?

Mr Butler uses Insulatard, intermediate-acting insulin. Ideally, insulin in a diabetic patient should mimic its physiological biphasic activity in a non-diabetic.

During fasting, sufficient insulin is released to inhibit the breakdown of lipids and glycogen, and to inhibit glucaneagenesis and protein catabolism. This activity is mimicked by long-acting insulin.

After a meal, insulin is rapidly released in response to increased blood glucose and this promotes the uptake of glucose into cells. Blood glucose levels are consequently lowered, thus decreasing the rate of insulin release. This is more difficult to mimic through injected insulin, because it continues to exert its effect after the blood glucose has fallen.

Insulin regimes vary widely and must be tailored to the need of the individual. Elderly patients with type 2 diabetes are sometimes unable to cope with more than one daily injection. For them, one injection a day with a long-acting insulin could provide a compromise.

Saturn stills/Science Photo Library

Elderly patients maybe unable to cope with more than one daily injection

More usually, twice daily injections of a combination of soluble insulin and isophane insulin provide the best compromise between good glycaemic control and compliance. Some patients combine a daily injection of long-acting insulin with an injection of short-acting insulin about 30 minutes before each meal.

Jill suggested that Mr Butler could talk to his GP or hospital consultant about perhaps changing to a combined soluble/isophane insulin injection.

What about the glitazones?

Two weeks later, Jill returned from a short holiday to find that Mr Butler had called in and left a file containing numerous press cuttings about a new drug, rosiglitazone, together with a note to ask if this drug was available. As his hospital consultant would probably be reluctant to use it, Mr Butler would be prepared to pay for a private prescription if necessary.

Rosiglitazone is a peroxisome proliferator-activated receptor gamma (PPARgamma) agonist. This group of drugs is also known as the glitazones or thiazolidinediones. They are thought to target the two fundamental causes of type 2 diabetes – insulin resistance and beta-cell dysfunction.

The first of this group to be launched, troglitazone, was withdrawn because it was found to cause hepatic toxicity. Rosiglitazone (Avandia) was launched earlier this year, and another drug – pioglitazone – has been launched more recently still (last month).

PPARgamma agonists are thought to increase insulin sensitivity at key sites in insulin resistance – adipose tissue, liver and skeletal muscle – reducing glucose release from the liver and increasing glucose uptake in skeletal muscle.

Rosiglitazone is licensed for use with a sulphanylurea, or with metformin in patients with insufficient glycaemic control. It thus provides an alternative to insulin therapy where conventional therapy is insufficient.

Treatment should be initiated by an experienced physician. Liver function should be monitored during treatment, although current data suggests that rosiglitazone is not hepatotoxic.

The National Institute for Clinical Excellence issued guidance on the use of rosiglitazone for type 2 diabetes in August. It recommended that patients should be offered rosiglitazone combination therapy as an alternative to injected insulin if:

- they are unable to take metformin and a sulphanylurea as combination therapy, or
- their blood glucose remains high despite adequate trial of this combination treatment.

Rosiglitazone plus metformin is preferred to rosiglitazone plus a sulphanylurea – particularly for obese patients.

Rosiglitazone is contraindicated in patients with cardiac failure, hepatic impairment and severe renal insufficiency. Adverse effects include fluid retention, anaemia and weight gain.

Jill obtained a copy of the patient leaflet on the NICE guidelines from the internet ready for Mr Butler when he next called. She explained that the hospital consultant would probably be reluctant to change things as he was fairly well controlled with his current therapy, but that he could discuss it at his next appointment.

Since therapy must be initiated by an experienced doctor and regular hepatic monitoring was needed, Mr Butler would be unlikely to obtain it other than from his hospital consultant. His cardiac condition might prove a contra-indication.

'And what about these anti-depressants?'

The following week, Mr Butler popped in again. He wanted Jill's views about his doctor's latest suggestion. For a while now he'd been suffering with painful neuropathy affecting his hands. The doctor suggested a low dose of amitriptyline to help with this, but Mr Butler felt he was being 'fobbed off'. His neighbour had used it for depression and suffered 'awful' side effects.

Jill told him that amitriptyline was effective in very low doses for neuropathic pain (an unlicensed use).

Other drugs used in painful diabetic neuropathy include aspirin and paracetamol, both of which may help with pain. Capsaicin cream is now licensed for diabetic neuropathy. Carbamazepine may be useful. Mexiletene, a membrane stabiliser licensed for use in cardiac arrhythmias may help in some patients.

Jill reassured Mr Butler that the small dosage was unlikely to cause side effects to the same degree as his neighbour, who would have taken larger doses to treat depression. She suggested that Mr Butler reminded the doctor about his AF (to pre-empt Mr Butler's inevitable questions about the effects of tricyclic antidepressants amitriptyline on the heart!).

Mr Butler agreed to talk again to the doctor about trying amitriptyline and told Jill he would let her know how he got on. Of that, at least, Jill felt very sure!

1996

- Communication and the Pharmacist (1001)
- Rheumatoid Arthritis (1002)
- ACE Inhibitors (1003)
- The Endocrine System (1004)
- Sleep Disorders (1005)
- Pituitary Problems (1006)
- Croup (1007)
- Hormonal Contraception (1008)
- Schizophrenia (1009)
- Psoriosis (1010)
- Constipation (1011)
- Methadone (1012)
- Methadone Supervision (1013)
- Beta-blockers (1014)
- Cystitis (1015)
- Palliative Drug Therapy (1016)
- Responding to Symptoms (1017)
- Drug Interactions Part 1 (1018)
- Drug Interactions Part 2 (1019)
- Malaria (1020)
- Headache (1021)
- Drugs in Sport (1022)
- Indigestion Part 1 (1023)
- Sexually Transmitted Disease (1024)
- Cannabis (1025)
- Indigestion Part 2 (1026)
- Diuretics (1027)
- Eating Disorders (1028)
- Coughs & Colds Part 1 (1029)
- Inhaler Devices (1030)
- Chinese Herbal Medicine (1031)
- Coughs & Colds Part 2 (1032)
- Hallucinogens (1033)
- Amphetamines (1034)
- Irritable Bowel Syndrome (1035)
- Acne (1036)
- Lower Back Pain (1037)
- Myalgic Encephalomyelitis (1038)

1997

- Calcium Channel Blockers (1039)
- Stoma Care (1040)
- Dry Skin Problems (1041)
- Parkinson's Disease (1042)
- Lice & Scabies (1043)
- Alcoholism (1044)
- Protease inhibitors (1045)
- Constipation (1046)
- Tuberculosis (1047)
- Haemorrhoids (1048)
- Cholesterol (1049)
- Lipid Lowering Drugs (1050)
- Allergic Rhinitis (1051)
- Skin Melanoma (1052)
- Snoring (1053)
- Benign Prostatic Hyperplasia (1054)
- Anaemia (1055)
- Nausea (1056)
- Aspirin (1057)
- Breast Care (1058)
- Osteoporosis(1059)
- Diarrhoea (1060)
- Hepatitis (1061)

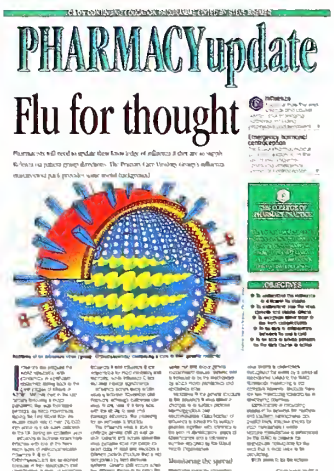
- Foot care (1062)
- Melatonin (1063)
- Diabetic Complications (1064)
- Volatile Solvent Abuse (1065)
- Poppy Rosh (1066)
- Erectile Dysfunction (1067)
- Dysmenorrhoea and Cystitis (1068)
- Obesity (1069)
- Mediterranean Diet (1070)
- Pneumococcal Infections (1071)
- Eye Problems (1072)
- Paediatric Medicine (1073)
- Anaphyloxis (1074)
- Ear Problems (1075)
- Chronic Obstructive Pulmonary Disease (1076)

1998

- Meningitis (1077)
- Dental Caries (1078)
- Benefits of Exercise (1079)
- Mouthcare (1080)
- Mental Health (1081)
- Anticoagulants (1082)
- Thrush (1083)
- Aromatherapy (1084)
- LCP Fatty Acids (1085)
- Musculoskeletal Injuries (1086)
- Enteral Feeds (1087)
- Whiplash (1088)
- Balanced Diet (1089)
- Thyroid Gland (1090)
- Angiotensin II Antagonists (1091)
- Stroke (1092)
- Nocturnal Enuresis (1093)
- Detoxification (1094)
- Accidental Poisoning (1095)
- Fat Soluble Vitamins (1096)
- Thyroid Disorders (1097)
- Food Poisoning (1098)
- Glaucoma (1099)
- Hair Loss (1100)
- Polycystic Ovarian Syndrome (1101)
- Toxoplasmosis (1102)
- Menopause (1103)
- NRT (1104)
- Eczema and Infection (1105)
- Repetitive Strain Injury (1106)
- Bowel Cancer (1107)
- Elderly I (1108)
- Elderly II (1109)
- Salt and Health (1110)
- Nutrition in Pregnancy (1111)
- Hearing Disorders (1112)

1999

- Phobias (1113)
- Antibiotic resistance (1114)
- Hypertension (1115)
- WHO Carbohydrates (1116)
- Seasonal Affective Disorder (1117)
- Pain (1118)
- Smoking Hazards I (1119)
- Drug Misuse Law (1120)
- Smoking hazards II (1121)
- Pharmacoeconomics (1122)
- Needle Exchange (1123)
- Childhood Vaccines (1124)
- Primary Care Groups (1125)
- Healthier Nation – Mental health (1126)
- Coeliac Disease (1127)
- Functional Foods (1128)
- Healthier Nation – Cancer (1129)
- Addiction I (1130)
- Healthier Nation – Heart Disease and Accidents (1131)
- Addiction II (1132)
- Scoring (1133)
- Systemic Lupus Erythematosis (1134)
- Depression and Compliance (1135)
- Generic Prescribing (1136)
- Generic Equivalence (1137)
- Treating Acne (1138)
- Anabolic Steroid Abuse (1139)
- Attention Deficit Hyperactivity Disorder (1140)
- Chlamydia (1141)
- Acromegaly (1142)
- Scalp disorders (1143)
- Infertility (1144)
- Stress (1145)
- Post-marketing Surveillance (1146)
- Domiciliary Care (1147)
- Antidepressants (1148)



2000

- Heroin (1149)
- Auto-immune Disorders (1150)
- Adverse Drug Reactions (1151)
- Allergies in the Home (1152)
- Chronic Daily Headache (1153)
- Endometriosis (1154)
- Transplants (1155)
- Asthma Triggers (1156)
- Evidence-based Medicine (1157)
- Heart Disease (1158)
- A Medical Herbalist (1159)
- Porphyria (1160)
- Services to Homes (1161)
- Migraine Misery (1162)
- Anxiety Disorders (1163)
- Treatment Options in Migraine (1164)
- Travellers' Diarrhoea (1165)
- The cost of NSAID-induced Bleeding (1166)
- Services to Homes (1167)
- Psoriasis (1168)
- Spasticity (1169)
- Nutrition (1170)
- Oral Contraceptives (1171)
- Drug Misuse (1172)
- Nutrition (1173)
- Case History: Rheumatoid Arthritis (1174)
- Type 2 Diabetes (1175)
- Alzheimer's Disease (1176)
- Type 2 Diabetes (1177)
- Emergency Contraception (1178)
- Benzodiazepine Misuse (1179)
- Varicella-zoster Infections (1180)
- Haemorrhoids (1181)
- Trace Elements (1182)
- Multiple Sclerosis (1183)
- Water Soluble Vitamins (1184)
- Constipation (1185)
- Influenza (1186)

Monthly MCQ papers for 2000 are numbered as follows. The codes apply for each month (the last two digits correspond to the last two digits of the first learning module which the MCQ paper covers):

January	2113
February	2116
March	2119
April	2122
May	2125
June	2128
July	2131
August	2134
September	2137
October	2140
November	2143
December	2146

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USSIN CHESTY COUGH MEDICINE - PRESENTATION Cherry flavour liquid for oral administration. Each 5ml contains Guaiphenesin Ph Eur 100 mg. INDICATIONS: Expectorant for the treatment of coughs. DOSAGE Adults, the elderly and ... times daily 1 - 6 years 2.5 ml four times daily. Under 1 year. Not recommended. CONTRAINDICATIONS Hypersensitivity to any of the ingredients. INTERACTIONS None documented. SIDE EFFECTS None documented. USE DURING PREGNANCY AND LACTATION ... cts in pregnancy and lactation is at present incomplete. However, wide usage for many years has shown no apparent ill consequences. OVERDOSAGE Nausea and vomiting. PHARMACEUTICAL PRECAUTIONS ... below 25°C. SHELF LIFE ... LEGAL CATEGORY ... PACKAGE QUANTITIES ... S (RSP ex vat) £2.89. Amber glass bottles of 100 ml. MARKETING AUTHORISATION NO. PL 0165/0097. MARKETING AUTHORISATION HOLDER: Whitehall Laboratories Limited, Huntercombe Lane South, Taplow, Berkshire, SL6 0PH. DATE OF PREPARATION ... ROBITUSSIN CHESTY H WITH CONGESTION COUGH MEDICINE - PRESENTATION Cherry flavour liquid for oral administration. Each 5ml contains Guaiphenesin Ph Eur 100 mg, Pseudoephedrine Hydrochloride BP 30 mg. INDICATIONS Nasal decongestant ... GE Adults, the elderly and children over 12 years: 10 ml up to 4 times daily. Children 6 - 12 years: 5 ml up to four times daily. 2 - 6 years: 2.5 ml up to four times daily. Under 2 years: Not recommended. CONTRAINDICATIONS Hypersensitivity ... oxicosis, glaucoma, diabetes, enlargement of the prostate or urinary retention. Patients currently receiving, or who have within the last two weeks received, monoamine oxidase inhibitors. Patients receiving tricyclic antidepressant ... cardiac arrhythmias may occur if sympathomimetics (such as pseudoephedrine hydrochloride) are given to patients receiving cardiac glycosides. Sympathomimetics may also increase blood pressure and therefore special care is adv... ptions. Not to be taken by patients receiving either cardiac glycosides or antihypertensive agents, except on advice from a doctor. Side effects: May act as a cerebral stimulant in children and occasionally adults. EFFECT ON ABILITY TO DRIVE AND USE MACHINES ... MPATIBILITIES ... E DURING PREGNANCY AND LACTATION. Should not be used during pregnancy unless directed by a physician. OVERDOSAGE Nausea and vomiting. CNS stimulation leading to excitement, restlessness, rapid speech, hallu... c lavage and general supportive measures should be used. PHARMACEUTICAL PRECAUTIONS: Store at a temperature not exceeding 25° C. SHELF LIFE: 4 years. LEGAL CATEGORY. P. PACKAGE QUANTITIES & PRICES (RSP ... MARKETING AUTHORISATION ... 65/0098. MARKETING AUTHORISATION HOLDER: Whitehall Laboratories Limited, Huntercombe Lane South, Taplow, Berkshire, SL6 0PH. DATE OF PREPARATION: November 1999. ROBITUSSIN DRY COUGH MEDICINE ... methorphan Hydrobromide Ph Eur 7.5 mg. INDICATIONS: For the relief of persistent dry irritant coughs. DOSAGE Adults: 10 ml three or four times daily. Children 6-12 years: 5 ml three or four times daily. Children under 6 ... NTERACTIONS. Use with caution in patients currently receiving, or who have within the last two weeks received, monoamine oxidase inhibitors. Special Warnings: Use with caution in patients with hepatic dysfunction. SIDE EFFECTS: ... IVE AND USE MACHINES: None known. INCOMPATIBILITIES: None stated. USE DURING PREGNANCY AND LACTATION: Not recommended. OVERDOSAGE: Gastric lavage and general supportive measures should be used. PHARMACEUTICAL PRECAUTIONS: ... CATEGORY. P. PACKAGE QUANTITIES & PRICES (RSP ex vat): £2.89. Amber glass bottles of 100 ml. MARKETING AUTHORISATION NO.: PL 0165/0100. MARKETING AUTHORISATION HOLDER: Whitehall Laboratories Limited, ... N NIGHT-TIME - PRESENTATION: Cherry/Grenadine flavoured liquid for oral administration. Each 5 ml contains: Brompheniramine Maleate Ph Eur 2 mg, Pseudoephedrine Hydrochloride BP 30 mg, Codeine Phosphate Ph Eur ... INDICATIONS: ... rated with colds and other similar conditions of the upper respiratory tract. DOSAGE: Adults: 5 to 10 ml up to four times daily. Children: 6 - 12 years: 2.5 ml three times daily; 4 - 6 years: 5 ml three times daily; 2 - 4 ... 2 years: Not to be used. CONTRAINDICATIONS: Hypersensitivity to any of the ingredients. Coma or pre-coma state, known brain damage or epilepsy. Patients with acute ischaemia, heart disease, thyrotoxicosis, ... who have within the last two weeks received, monoamine oxidase inhibitors. Patients receiving tricyclic antidepressants. Patients receiving other sympathomimetic drugs. INTERACTIONS: May potentiate the effects of ... an increased risk of cardiac arrhythmias may occur if sympathomimetics (such as pseudoephedrine hydrochloride) are given to patients receiving cardiac glycosides. Sympathomimetics may increase blood ... INGS AND PRECAUTIONS: Not to be taken by patients suffering from bronchial asthma or taking either cardiac glycosides or antihypertensive agents, except on a doctor's advice. Children receiving this medication should ... mmon with many other antihistamines, brompheniramine has an atropine- like action and therefore should be used with caution in patients with bronchial asthma, especially children. Tolerance, psycho-logical and physical dependence ... ually in adults. If this occurs it is possible that insomnia, nervousness, hyperpyrexia, or tremor may occur and very rarely epileptiform convulsions. Therefore children taking this product should not be left unsupervised. ... ould not drive or operate machinery unless it has been shown that their physical and mental capability remains unaffected. INCOMPATIBILITIES: None stated. Use during pregnancy and lactation: Not to be used ... timulation leading to excitement, restlessness, rapid speech, hallucinations, hypertonicity and hyperreflexia, dilated pupils and tachycardia. Loss of consciousness, hypotension, coma, occasionally convulsions. Respiratory ... PHARMACEUTICAL PRECAUTIONS: None stated. SHELF LIFE: 2 years. LEGAL CATEGORY: P. Package Quantities & Prices (RSP ex vat): £3.02. Amber glass bottles of 100 ml. MARKETING AUTHORISATION NO.: PL ... MARKETING ... combe Lane South, Taplow, Berkshire, SL6 0PH. DATE OF PREPARATION: November 1999.

†*Robitussin* is the fastest growing cough liquid brand in Pharmacy – Information Resources MAT October 2000. *Trade Mark.

The oral contraceptive pill first became widely available in Britain in 1961. On its 40th birthday, Steve Bremer reviews the history of 'one of the top ten greatest inventions' of the last century

Happy birth control day

The oral contraceptive was rated as "second only in importance to the nuclear bomb" by *The Lancet* when it first became available in the early 1960s. It qualifies as "one of the top ten greatest inventions of this century without a doubt", according to the Family Planning Association's director of information, Toni Belfield.

Oral contraception dramatically changed the outlook for family planning. Before the pill became available, 97.5 per cent of new clients at family planning clinics were advised to use the cap, 1.5 per cent the sheath, and 0.5 per cent were told to use just chemicals. Only ten years later, 58 per cent of clinic patients were being prescribed the pill, 16.5 per cent the cap, 13 per cent an intrauterine device, and 2 per cent the sheath. By 1973, almost 20 per cent of British women aged 15-44 were taking the pill.

It had taken ten years from the first synthesis of oestrogen and progestogen by Carl Djerassi to the launch of the first commercial product in this country. It was being trialed on Haitian women by Pincus and Garcia in 1956, but did not become widely available in Britain until the spring of 1961.

The first product on the UK market was Conovid, manufactured by Searle. Conovid contained norethynodrel 5mg and mestranol 75mcg. In today's terms, this was an extremely high dose - one tablet contained the hormonal equivalent of a week's worth of a typical pill now. Conovid was followed by Anovlar from Schering. Today, there are 33 branded oral contraceptives, of which 27 are different.

If taken according to instructions, the combined pill is over 99 per cent effective. This means that fewer than one woman in 100 will get pregnant in a year. It is more effective than the male condom - 98 per cent, and the cap with spermicide - 92-96 per cent effective.

The pill in the '60s

Initially, the pill was mainly available through family planning clinics (which were then run by the FPA).

Image Bank

The pill had a huge social impact during the '60s

Before 1961, doctors had no role in contraception, because it was deemed a social rather than a medical issue, and contraception was purely mechanical. However, a contraceptive drug gave them a legitimate interest in birth control.

Doctors were initially unsure about their new role and their reaction to the pill was mixed. The *British Medical Journal* at the time considered that a much larger collection of data was needed before a clear assessment of the safety and efficacy of the pill could be made.

The NHS position was also confused. Patients could only be prescribed the pill under the NHS on medical grounds, and doctors could be called upon to justify their reasoning to the Ministry of Health. In 1964 it was decided that, in the absence of medical grounds, doctors could issue private prescriptions for NHS patients provided that they made no charge for the service. Women had to pay for the pill right up until 1974.

When the pill first became available, women had to prove that they were married before it could be supplied. Marriage certificates or similar evidence had to be shown. This requirement persisted until 1968.

Although the pill had a huge social impact, it is difficult to quantify because of other influences in the '60s. Ms Belfield does not believe that it made women more promiscuous. "Some people say that the pill was the advent of sexual promiscuity but that's not true," she says.

Women were probably more promiscuous during World War II, she believes. During the War, people believed in "love today and worry tomorrow". This was not the case during the '60s. "We need to be honest about what was going on then. If unmarried women became pregnant, the social stigma was enormous."

The Pope and the pill

Oral contraception presented the Catholic Church with an unprecedented dilemma, forcing the Vatican to re-examine its views on birth control. The pill was the first contraceptive that did not act mechanically and this contributed to the division of Catholic opinion. It could be argued that the pill was a 'natural' form of contraception, which did not cause the 'natural' expression of love to be 'interrupted' by the application of a chemical or manufactured contraceptive.

The problem was how to reconcile these new circumstances with the unchanged views of the Catholic hierarchy on birth control. These were reiterated by Pope Pius in 1958, when he condemned "deliberate intention and positive action taken by any means to deprive sexual union of its procreative potentiality".

Despite the official Vatican view, most practising Catholics acted in defiance of their church's ruling. The Population Investigation Committee's 1967-68 marriage survey found that 80.3 per cent of British Catholic wives married between 1961-65, used birth control, compared to 94.5 per cent of non-Catholic wives. They used the pill nearly as much as non-Catholics - 30.2 per cent compared to 30.5 per cent.

Debate in the Catholic Church continued throughout the '60s, until Pope Paul made the definitive statement in 1968. His encyclical letter 'On the regulation of birth - *humanae vitae*', forbade the use of contraception other than by 'natural' means.

The Pope called on governments to ban contraception by law, and warned that its use could lead to marital infidelity, immorality among the young and a general lowering of moral standards.

This statement was highly controversial, and ultimately most Catholic bishops made a compromise in the final choice, individual

Table 1: Estimated annual deaths per 100,000 women in the US (taken from the National Institutes of Health)

Cause of death (Ages)	15-19	20-24	25-29	30-34	35-39	40-44
Childbirth	5	6	7	13	21	22
Pill complications, smokers	2	4	6	12	31	61
Pill complications, non-smokers	1	1	2	3	9	18
All causes, including accidents	54	67	74	98	146	237

Box 1: Pill risks

There is more chance of dying in childbirth than from a pill complication, except for pill users who smoke and are over 35.

Minor side effects include nausea and vomiting (usually only in the first few cycles), weight changes, breast tenderness, abdominal cramps or skin discolouration. Bladder and vaginal infections are more common with pill use. Some women report changes in libido, a loss of scalp hair, or an intolerance of contact lenses due to water retention.

The most serious side-effect is the increased risk of cardiovascular disease, specifically blood clots, heart attacks and strokes. These complications now happen less often as a result of lower hormone content, better screening, and a fall in pill use by women over 35.

Pill-related heart attacks occur in an estimated one in 14,000 users between the ages of 30 and 39. Between 40 and 44, the risk increases to about one in 1,500.

Strokes occur five times more frequently among women taking an oral contraceptive, but they are still rare, affecting about one in 2,700 pill users.

Most women who have a heart attack or stroke while on the pill are smokers, but the mechanism is not fully understood. This is shown by the fact that either using an oral contraceptive or smoking increases the chances of having a stroke by about six times, but this rises to 22 times for women who both smoke and take the pill.

When more than one risk factor is present, the chances of a serious pill complication increase dramatically. For example, the odds of having a heart attack are increased by:

- *three times among pill users*
- *five times among smokers*
- *eight times among people with high blood pressure*
- *170 times among pill users with high blood pressure who smoke.*

Box 2: Pill benefits

Figures from the American National Institutes of Health show that each year in the US, the pill prevents:

- 51,000 cases of pelvic inflammatory disease, 13,300 of which would have required hospitalisation
- 20,000 hospitalisations for certain types of non-cancerous breast disease
- 9,900 hospitalisations for ectopic pregnancy
- 3,000 hospitalisations for ovarian cysts
- 27,000 cases of iron deficiency anaemia
- 2,700 cases of rheumatoid arthritis

Protection against pelvic inflammatory disease (PID) may be the most important non-contraceptive benefit of the pill. A bacterial infection of the uterus, fallopian tubes, or ovaries, PID affects an estimated 850,000 US women each year. PID can lead to infertility, or rarely death. Women on the pill have half the risk of developing PID of women using no form of birth control.

Other advantages of the pill include less menstrual cramping, lighter blood flow and for those using combined products – regular periods. Some women also experience a decrease in premenstrual tension. Acne sufferers often experience an improved complexion.

conscience should be free, albeit through informed awareness of the Catholic Church teaching.

Scares and evidence

As well as being one of history's most important inventions, the pill is one of its most studied medications. The three most important studies have been:

- The Royal College of General Practitioners' study, which began in 1968. It is still ongoing, although no longer recruiting
- The Oxford FPA study, which compared the oral contraceptive to the diaphragm, cap and IUD. It also started recruiting in 1968 and is still reporting
- The US nurses study, which is similar to the Oxford FPA study.

The first big 'pill scare' broke in 1969 when the Committee on Safety of Medicines stated that the incidence of thrombosis was higher among women taking pills containing higher doses of oestrogen than those taking a lower dose. It advised doctors not to prescribe preparations containing more than 50mcg of oestrogen. The FPA announced that it had already begun to prescribe lower dose oestrogen and expected to give up high-dose formulations altogether.

In 1974, the Department of Health and Social Security published a 'Handbook of Contraceptive Practice' claiming that the withdrawal of high dose preparations had substantially reduced the average pill-taker's mortality risk.

Lingering doubts should have been dispelled in the same year when the RCGP published its interim report on 'Oral contraceptives and health'. This was the most extensive oral contraception study that had been undertaken. The report, based on observation of 46,000 women in 1,400 general practices over four years, concluded that the risk of using the pill was one that a properly informed woman should be happy to take.

All these studies obviously looked at older, higher dose pills, which are more problematic than the modern, lower-dose versions.

Results from a RCGP study published in 1999 are "most startling", according to Ms Belfield. This study looked at overall mortality and found that when the pill is prescribed to women who do not smoke and have no other medical problems, if they have been properly screened then their risk is the same as women who do not take the pill.

Ms Belfield claimed that studies that have looked at thrombosis and stroke have included patients who should have been screened out, such as some smokers and those with a family history. "For many years there was not enough screening. It has improved but there's still room for improvement," she says.

There is an increased risk of thrombosis with the pill, but it is tiny and needs to be put in perspective. Figures per 100,000 women are:

- those not taking the pill and not pregnant – 5
- those taking second generation pills, ie those containing levonorgestrel – 15
- those taking preparations containing the newer progestogens, ie desogestrel and gestodene – 25
- pregnancy – 60.

But still the debate about thrombosis risk continues. Risks are much higher for those with a family history, women with very severe varicose veins, and wheelchair users. For pill users who smoke, the major risk is from smoking, not the pill. For other risks associated with pill taking, see box 1.

Research has also shown that taking the pill has health benefits. It cuts the risk of endometrial and ovarian cancer by half, for example. For other benefits of pill taking, see box 2.

Pharmacists can ensure that patients are given accurate information, says Ms Belfield. "Although they are not prescribers, they are often information providers."

Today, 24 per cent of women between the ages of 16 and 49 take the pill, compared to 18 per cent who use condoms, and 15 per cent who use IUDs. Pill use was at its peak in the late 70s early 80s. One study, although not strictly comparable with today's figures, put pill use at its peak at 65.8 per cent in 1976.

It is difficult to compare figures between now and then. Women have 13 contraceptive choices today, but their options used to be much more limited. Pill use is stable at present, and its main users are under 25

There is still a prescribing bias around women over 35, claims Ms Belfield. But women can safely use the pill until the menopause if they do not smoke or have medical problems

Future possibilities

Despite the current wide range of contraceptive choices, the future offers still more. A male contraceptive, which will probably combine either an implant or a tablet and a patch, is expected to be available within the next seven years. It will probably be used in committed relationships, and probably not by younger people.

Despite its success over the last 40 years, Ms Belfield does not expect the oral contraceptive to be the method of choice in another 40 years' time. "I think we should look more widely," she says.

One possibility is that women may bank their eggs to be used at a later date. This would remove the need for contraception as we know it. Another possibility is for a weekly or monthly dose of the oral contraceptive. A contraceptive pill of the future could contain an additional ingredient that protects against sexually transmitted infection. Different hormonal delivery systems are also a possibility.

- Contraceptive awareness week is on February 11-17.
- The FPA helpline offers advice and support to both the public and professionals. It can supply support material and information leaflets. The number is 0207 837 4044

Trusts must engage with pharmacists

Martin Hill

Scottish NHS trusts must engage with pharmacists to get the best use of medicines, but while LHCC pharmacists are getting involved, contractors appear less willing.

"Between a quarter to a third of my annual budget is for drugs. Pharmacists are the people with skills, access and ability to manage this resource. We have got to engage with pharmacists.

"There is a significant desire to get involved by LHCC pharmacists, which is much more marked than from individual contractor colleagues," said Martin Hill, chief executive of Lanarkshire Primary Care NHS Trust and chairman of the Scottish Executive LHCC Best Practice Reference Group.

The Scottish NHS Plan has a quite "distinctive feel", he added. "There are actually not that many surprises and it reinforces much of the work that people are already involved in. As a result there is already a degree of buy-in. The importance of having that head start should not be underestimated."

Over the four year period 1999-03 the Scottish NHS will get a £1.8bn increase in funding - a 35 per cent increase in resources. The challenge for the NHS is to ensure that the money does not get lost in the bureaucratic system. "The NHS needs to ensure that if it is serious about improving local teams and developing local plans then there are the resources to do it."

This gives opportunity for LHCCs to make a difference in their communities. High on the list of priorities is dealing with issues of social exclusion, said Mr Hill. There needs to be positive discrimination in favour of those communities that have the least healthy lifestyles - and that is going to be difficult.

The NHS Plan is committed to developing LHCCs, but a lot of people have still to be convinced of what they can do, he believes. "We need to make sure people know what is happening, we need to work out how to increase the influence of LHCCs in planning and delivering services. We need to achieve credibility if we are to sell the LHCC concept."

One of the strengths of individual contractor is their entrepreneurial flair. It is often underestimated, but it can be harnessed through the collectivism of the LHCC.

Pharmacy agenda being pushed in LHCCs

Scottish pharmacists are beginning to punch their weight in local healthcare co-operatives, but there is still a way to go, as those at a conference at Dunblane heard last weekend

It is a measure of the interest that pharmacists have in pushing their agenda within the new NHS that there were over 200 applications for the 100 places available at last weekend's LHCC conference.

There is obviously a vast gulf in experience between the newer LHCC recruits and old hands such as Sheena Macgregor, who has been championing pharmacy practice within the multidisciplinary team in the Borders and elsewhere for years.

"There are lots of exciting schemes being generated by pharmacists. The challenge is about rolling these schemes out on a national basis," RPSiS chairman Alison Strath said. "Building on the model schemes we have and extending them, conducting medication reviews, and improving the provision of repeat medication are all things we are committed to."

The NHS Plan for Scotland sets out a direction of travel. Local as well as national partnership is important, and LHCC pharmacists are the profession's local PR units, she said.

Presentations from some delegates made clear, however, that pharmacists face mixed fortunes in the struggle for representation, recognition and funding. Alister MacLaren, primary care lead clinical pharmacist in Greater Glasgow, painted what is perhaps a typical picture.

Glasgow has 16 LHCC pharmacy groups. A network of LHCC co-ordinators, initially funded by the Health Board, has been set up to raise the profession's profile. "Three LHCCs have no representation and the involvement of others is variable," he reports. "Eight LHCCs have pharmacists on at least one project group, and four have a pharmacist on the executive."

Some 65 per cent of pharmacy contractors participated in audit programmes last year. Forty participated in a smoking cessation project, and there are plans to extend it to 100 more pharmacies in the Health Board area.

Mr MacLaren's embryonic network has its problems. He cites varying degrees of expertise and development, and insufficient support for LHCC co-ordinators. As many contractors pointed out, an LHCC commitment often means committing to a locum for at least half a day, and meetings are often cancelled at short notice.

Alister MacLaren, primary care lead clinical pharmacist in Glasgow, and Glasgow Eastern LHCC co-ordinator Francesca Lee

The programme in the Borders Health Board area has chalked up some successes. Smaller numbers - 25 community pharmacies and 79 registered pharmacists - have made some projects easier. A clinical training programme saw 16 pharmacists being accredited in late 1999. Plans last year to cut waste from the prescribing budget and invest the savings in local practices were wiped out by the escalating price of generic drugs.

"Most of what we have achieved in Borders is not new or mindblowing," said Sheena Macgregor. "We are trying to achieve integration of pharmacists into the multidisciplinary team so that we can work together in the future."

For 2001, designated pharmacists will be associated with each GP practice. The PCT has agreed that they will be put on the payroll for sessional work in the same way that GPs are when they work in community hospitals.

Agreed prescribing indicators and a new repeat prescribing system are also planned for this year.

Waste medicines cost Glasgow £500,000

Close to £500,000 of medicines a year may be wasted in the Greater Glasgow Health Board area, suggests a study in Anniesland-Bearsden-Milingavie LHCC.

Data on returned drugs was collected for four weeks in February/March 2000 from all ten pharmacies in the LHCC. A total of 256 items costing £2,411 were returned by 100 patients, mainly because therapy had altered (54 per cent) or the patient had died (16 per cent). Cardiovascular drugs topped the list of returned medicines.

There was some evidence of excessive prescribing. Three pharmacies and two GP surgeries accounted for 61 and 68 per cent of returns respectively. Some changes to prescribing frequency have been agreed locally.

E M McGovern, S Tennant, C Mackay, Glasgow Pharmacy Audit programme

Sheila Tennant collects the prize for the best poster at the conference from chief pharmacist Bill Scott

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With the UK e-pharmacy market still in its embryonic stage, what can we learn from the experts? Guy L'Aimable reports from Access Conference International's recent e-pharmacy conference in London.

Embarrassment of riches

Pharmacy2U has confirmed that products dealing with embarrassing problems are among its most lucrative lines. Its best-selling line is a treatment for baldness and its healthcare links include the UK-based web site: *www.embarassingproblems.co.uk* which has often led potential customers to the online pharmacy.

P2U's top five medicine categories in October 1999 were:

1 hair and scalp
2 pain
3 indigestion
4 coughs/colds
5 smoking cessation.

Dr Julian Harrison, P2U's business development director, says: "We [initially] underestimated this opportunity [to treat embarrassing problems], but embarrassed purchases are vital to us now."

OTCs accounted for 57 per cent of its business to consumer sales in October, healthcare lines (including VMS) 15 per cent, and scripts 9 per cent.

During that month, 76 per cent of all customers were new to P2U, 24 per cent were repeat customers and 18 per cent were loyal. P2U is particularly keen on repeat and loyal consumers because they tend to spend more than new ones. "It's expensive to attract new customers," says Dr Harrison.

P2U's customers fall into four categories:

- busy executives with no time to visit a bricks and mortar pharmacy
- mothers with children, who order bulky items
- people with embarrassing problems
- the elderly/disabled, who are unable to get out.

Its B2C business accounted for 41 per cent of its sales in September, and B2B for the remainder.

Meanwhile, as P2U gears up for the electronic script revolution (*C&D* December 23/30, 2000, p24), it is trimming costs. It relaunched its web site last October with 7,000 lines – it previously had 10,000.

It currently has 21 employees and, despite its plans for new business opportunities, will not be recruiting many more over the next 12 months.

P2U says it does not matter whether you decide to concentrate on B2B or B2C – providing you can offer a good service with your current resources and can make a profit out of it.

Don't abuse your data

A data protection expert has warned e-pharmacies not to fall foul of the European Union's Data Protection Directive when they set up consumer databases.

Louise Fullwood, a lawyer at Pinsett Curtis, says the directive has eight basic principles:

- process data fairly and lawfully
- obtain data for specific and lawful purposes
- data should be adequate, relevant and not excessive
- it should be accurate and kept up to date
- keep data no longer than necessary
- process it in accordance with consumer rights
- take measures against unauthorised processing
- do not transfer data outside the European Union unless it is adequately protected.

The UK, according to Ms Fullwood, has taken a hardline stance in this area. "The British Data Protection Commissioner has said that if she finds breaches in any UK web sites, she'll fine the sites and write to the consumers whose data has been abused. This is a worse punishment because the sites may then face class actions," she says.

In the UK, she adds, password encryption will be the minimum standard that will probably be introduced when electronic prescriptions are launched.

E-pharmacies need to give people "fair collection notices" when they collect data from them. They therefore need patients' consent before the data can be collected.

"If you change your mind about how you want to use the data, you cannot do so unless you go back to the consumers involved (and get their permission). So you must think about how you plan to use consumer data in the future," she says.

Forms asking for data should be brief – that will ensure people will fill them out.

E-pharmacies should also comply with the data protection legislation of other countries they operate in. They should ideally take local advice on this.

Web site disclaimers, which limit sales of medicines to countries with the appropriate market authorisations, should be highly visible.

Brand recognition

Boots and other well-known companies have an immediate advantage in setting up web sites because they have powerful brand names, according to a digital media and branding consultant.

Stephen Byrne, digital strategy director at London-based Nucleus, says customers have an affinity with well-known brands which will cross over to the internet, providing the companies' web sites meet their needs and are understood and trusted.

Boots The Chemists' web site – *www.boots.co.uk* – has a high awareness among online consumers and is considered ahead on this criteria to other online pharmacies, such as Pharmacy2U, planet medica and drkoop.co.uk.

An aspiring commercial web site must understand its customers. "Forget eyeballs as a measure of success. Forget page impressions and dwell times. It's how long your most profitable customers are online and their propensity to spend," he says.

Developing an online 'brand', however, takes time and investment. Companies are advised to research their planned markets thoroughly, find out their expected rate of return and the cost of acquiring online customers, and to be prepared to innovate constantly.

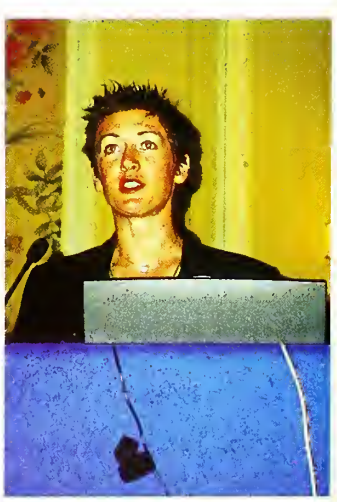
"Most pure-play brands have been founded by people who don't understand or know much about branding," he says, "and most have sought to brand a fleeting product or services, rather than the company capability."

Many online companies have also delayed creating a one-to-one relationship with their customers until it was too late – and have then blamed technology for their problems.

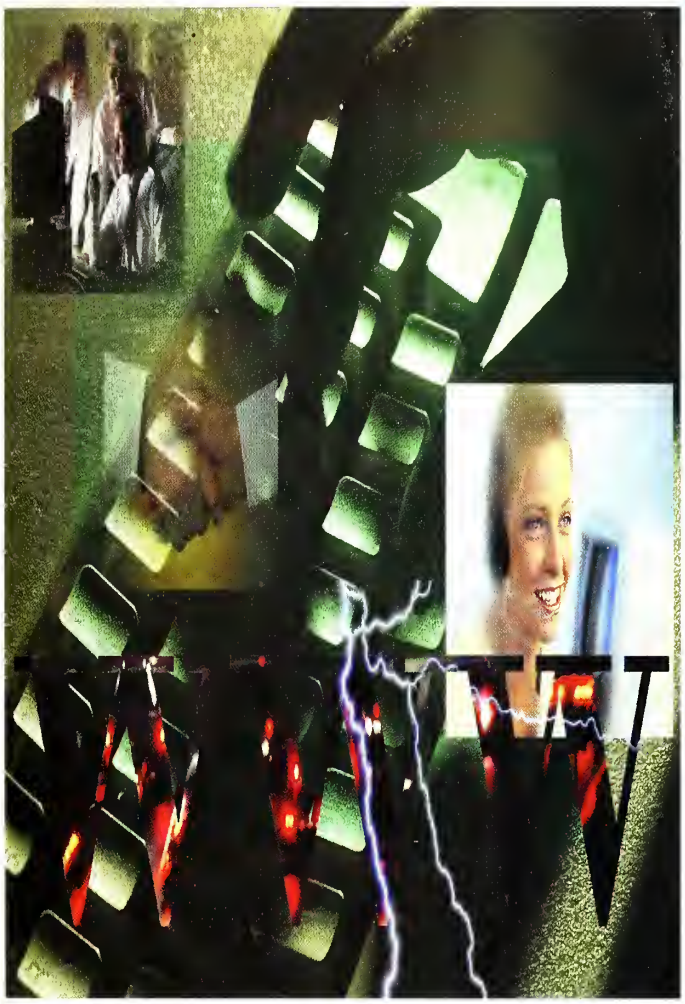
To create a powerful pharmacy you must:

- invest in the best technology
- communicate constantly with customers to find out what they want
- collaborate with the appropriate business partners who can bring in expertise in other areas

Dr Julian Harrison, P2U's business development director



Louise Fullwood, Pinsett Curtis lawyer



Stephen Byrne, Nucleus's digital strategy director

- create a streamlined, process for using the web site.

Companies should not put images on their site just for the sake of it, partly because images tend to slow down the downloading. "Put images that mean something to your customers," he says.

Similarly, do not put content that is not relevant to your customers on the web site.

Make sure the web site is well organised and practical – the overall effect should be to interest and engage potential customers, while creating a reassuring, familiar environment that makes them feel comfortable.

The range of colours the web site displays should be close to your corporate colours. Ideally they should be "warm, calm, friendly and easy on the eye... Pink and yellow are not good colours because they make the site hard to read".

Your typography should be simple and clear, and symbols should be used to provide quick and easy shorthands.

Navigation should be easy and direct. All the site's areas should be accessible quickly and smoothly. The user should be able to know where they are at any time, and how to get where they want to be. Clear and concise graphics should make it easy to access the desired areas.

Online positioning statements on the site, according to Mr Byrne, are important because they help people to find out what they are looking for in a new web site.

Boots The Chemists' web site is cited as an ideal example of how to impress customers – its positioning statement is 'Just for you'.

A survey found that customers considered the site excellent for: trust, service support, consistent reach, caring, understanding and friendly; and average for superior products and price.

You can breathe easy, says Baker Norton!

The **Xrayser** article 'New name – old problem' correctly states that the brand names of Easi-Breathe have reverted back to the original Baker Norton brands of Beclazone and Salamol.

Changes of this type inevitably cause some disruption, for which we apologise. However, we have been working with Glaxo Wellcome, general practitioners, computer prescribing software manufacturers and all major wholesalers over the last few months to ensure that the transition occurs with the minimum of disruption. In fact, we have:

- mailed all UK pharmacists, GPs, health authority personnel and wholesalers informing them of the transition
- been working with individual customers to remedy any specific issues
- stocked and maintained over 40 main wholesaler brands in the UK with the new packs.

While keeping all relevant parties informed of the transition we have worked closely with the distribution chain to ensure that the transition of Glaxo Wellcome brands to Salamol Easi-Breathe and Beclazone Easi-Breathe is seamless despite the complex logistical issues involved. We can assure **Xrayser** and the rest of your readers that throughout the period:

- all major wholesalers have been in stock of Easi-Breathe
- at no stage have we been unable to supply Easi-Breathe to the market.

Any short-term local supply issues that may have arisen have now been resolved. Anybody experiencing any Beclazone or Salamol Easi-Breathe supply issues should ring our Easi-Breathe freephone helpline on 0800 028 69 86.

Anton Jenkins
Head of Sales and Marketing, Baker Norton

Independent pharmacy – the end?

Before Christmas, I was trying to obtain sodium bicarbonate tablets from Norton Healthcare. This uniquely innovative and novel product had been unavailable for several weeks, for the second time this year, due to an "unexpected demand" and an impending transfer to patient packs. This means no-one remembered to order the boxes after the tubs ran out.

I was informed that the new stock had been released on Tuesday and would be in stock, except that my wholesalers had been excluded from the distribution. Apparently, first stocks "always go to Lloyds and UniChem, of course".

Subsequently, I learned that Boots, too, was permitted stocks, but not independent wholesalers and thus, independent pharmacies.

The lady concerned was quite plain that this is company policy, could see nothing wrong in reserving stocks for selected large multiples and did not understand why I was upset.

If this situation is allowed to continue, it will truly herald the end of independent pharmacies. I use the largest independent wholesaler in the country, and it is not allowed stocks until the second tranche of stock arrives. The other so-called wholesalers earn a substantial part of their UK profits from the retail side of the business.

No doubt Baker Norton will claim I misheard, or misunderstood, but the policy was made perfectly clear – there was no misunderstanding.

David Stuart
Stretford, Manchester

Lloydspharmacy's Holdenhurst Road branch, in Bournemouth, has been named the SmithKline Beecham/Lloydspharmacy team of the year. Teams were assessed on five areas – how effective they were in developing a highly-skilled workforce, building special relationships with customers, establishing and maintaining properly-equipped and efficient pharmacies, creating a comprehensive range of products and services and, finally, understanding the financial performance of the business. The winning team was presented with a cheque for £1,500 and a trophy

APPOINTMENTS

Ceuta Healthcare has appointed three new directors. **Neil Murphy** has joined the Board as Group Sales Director. Mr Murphy was previously group sales director for Gillette (Asia/Pacific).

Neil Murphy

David Mair has been appointed non-executive chairman of the board, of which he has been a non-executive member for the past three years. Mr Mair is a former chairman of UniChem.

Andrew Sollitt

Yvonne Sherry becomes Ceuta's Finance Director. Ms Sherry previously worked for Bradford NHS Trust.

Numark has appointed **Andrew Sollitt** as its marketing director. He joins Numark from Pubmaster, the national licensed retail operator, where he was head of marketing. Mr Sollitt's previous employers include Marks & Spencer and Specsavers. He takes over from David Wood, who became deputy managing director 12 months ago.

Mike Rudin has joined financial services provider Pharmacy Partners as the company's national product manager. Mr Rudin, who is a former member of the Pharmaceutical Services Negotiating Committee (PSNC), has a long history of working in community pharmacy, both in the independent and multiple sector. As such he developed the Tesco pharmacy chains, both concession and Tesco-owned, and has held the post of superintendent pharmacist for various companies.

Lever and Elida merge UK subsidiaries

Unilever has merged UK subsidiaries Lever Brothers and Elida Fabergé to form a €1 billion (£631m) business under the name Lever Fabergé.

The joint UK operation will be headed by Keith Weed, currently chairman of Elida Faberge. Lever Faberge will have a combined product portfolio, which includes brands such as Persil, Lynx, Comfort, Domestos, Sure and Cif. The two subsidiaries share a head office and are already trading under the new name. However, both Lever Brothers and Elida Fabergé will continue to exist legally until mid-2001.

Is Superdrug for sale?

WalMart, the US parent company of retailer ASDA, is believed to have expressed an interest in buying Superdrug from its current owner, Kingfisher, according to speculations in the weekend press.

Several reports suggested that Kingfisher was preparing to ditch the plans it had made for the summer to de-merge its general merchandise interests from its DIY and electricals business in favour of a sale.

A spokesman for Kingfisher confirmed that the company had been approached about selling Superdrug, but insisted that it was not in talks with anybody. He would neither confirm nor deny whether the offers related to the division as a whole or Superdrug alone.

"The de-merger remains on track for completion in the second quarter of this year," the spokesman said.

He did, however, add that the company was currently considering the bids while remaining convinced that a de-merger was the best way to maximise benefits for shareholders.

ASDA-WalMart would not comment on the rumours. Initial estimates suggest that Kingfisher could receive around £1.5m for its general merchandise interests, with Superdrug valued at £300m-£350m.

A sell-off would provide Kingfisher with the funds to expand its core business of DIY and electricals, and finance possible acquisitions.

Other companies mentioned as possible buyers of the Superdrug chain include Canadian Shoppers Drug Mart, as well as US pharmacy chains Walgreens and CVS.

On the other hand, a management buy-out of the general merchandising division by a team led by Martin Toogood was mentioned as another possibility.

Investors seemed to be unsettled by the speculations and Kingfisher shares lost around 13 per cent in value.

- *Superdrug.com*, Superdrug's recently launched web site, has signed a one-year partnership with *Netdoctor.co.uk*. *Superdrug.com* will be integrated into the healthcare site, allowing consumers to buy products online. In return, *NetDoctor.co.uk* will feed healthcare information into Superdrug's web site.

Festive tidings none too merry for Boots

Boots The Chemists reported a two per cent drop in its pre-Christmas sales compared with 12 months ago. However, the company also said that the real cost of withdrawing from non-core leisure ranges was closer to 5 per cent.

"As anticipated the managed exit from non-core leisure ranges has given rise to a decline in total sales, but a good increase in margins," said Steve Russell, chief executive, the Boots Company plc.

Withdrawing many gift and electrical ranges from its stores in favour of health and beauty products led to sales in the non-core leisure category falling by almost 40 per cent in the 13-week period before Christmas.

Asked whether withdrawing these ranges before Christmas had proved to be the wrong choice, a spokesman for the company said that "the exit from those non-core ranges was always going to hit the top line in one year or another. Luckily we chose a year where retail sales were weak in general".

While the Health and Beauty category saw a modest increase of 3.6 per cent, OTC sales were down by 8.3 per cent, which the company blamed on the much lower incidences of flu and colds. The launches of the first two Well-being centres, 16 new dental care practices and 13 new chiropody practices has led to increases in those categories of above 100 per cent.

There was bad news for Boots' shareholders, as speculation about a possible sell-off of Superdrug sent the company's share-price tumbling. Shares finished 23p down at 549p before recovering slightly the following day.

- Boots The Chemists is recruiting for a Head of Clinical Governance, with responsibility for developing and implementing the company's clinical governance strategy (see p8).

Ex-DP director claims unfair dismissal

A former director of Doncaster Pharmaceuticals Ltd (DP) is taking the company before the employment tribunal, claiming unfair dismissal because his resignation was allegedly obtained under duress.

Andrew Coyne was a director of DP between August 1999 and February 2000. He told *C&D* that before his departure he had spearheaded a management buy-out of the company and had set up a holding company (Hayeselect107) to buy DP assets.

However, Gary Tobin, the lawyer acting on behalf of DP, said that his understanding of the situation was that Hayeselect107 had been in financial difficulties and DP had stepped into the breech.

DP's lawyer added that Mr Coyne had renegotiated a proposed resignation package, which he had subsequently accepted.

Mr Tobin also pointed out that as far as any alleged issues surrounding the take-over of DP were concerned, these would not be considered by the employment tribunal. DP was eventually acquired by Salford-based wholesaler Mawdsley Brooks.

Both parties told *C&D* that they would favour a mutually acceptable settlement before the matter comes before the tribunal.

"We have been making offers to settle this amicably all year. The ball is very much in Mr Coyne's court," said Richard Freudenberg, DP's managing director.

The tribunal is scheduled to take place in Stockton-on-Tees in the early part of next week.

Co-op Health Care takes stake in Hadley

Co-op Health Care Ltd has acquired a 50 per cent stake in computer system's supplier Hadley Healthcare Ltd (HH) for an undisclosed sum. The company, which is owned by United Norwest Co-op and runs 124 pharmacies, will inject 'substantial funds' into Hadley Healthcare.

HH is expected to use the money to develop its eclipse Patient Medication Records system further. Co-op Health Care Ltd is said to have been particularly impressed by the system, which was launched in August 1999.

"High quality IT systems are the key to a successful pharmacy business, especially with the current five months wait for the Prescription Pricing Authority to calculate NHS remuneration," said Artie Chalmers, general manager of Co-op Health Care.

HH also plans to develop a comprehensive head office data collection and analysis package. Other projects include the electronic transmission of prescriptions, integrated internet applications and a fully integrated EPoS system.

HH was set up by Mike Hadley 19 months ago. He originally owned half the company, but bought out his business partners in March last year, assuming sole ownership of the company.

UniChem to close Walthamstow depot

UniChem is to close its Walthamstow depot at the end of June, when the current lease runs out.

From July the depot's existing customer base of around 400 pharmacies will be served by the UniChem branches in Letchworth, Croydon and Chessington.

UniChem's managing director, Chris Etherington, said that the branch was "nearing the end of its useful life and is not suitable for upgrade". He added that weekend and evening orders for Walthamstow customers were already supplied by the Letchworth depot.

Chris Etherington, managing director of UniChem

UniChem is confident that because of increased levels of automation and state-of-the-art technology the company has installed in its branches nationwide, the other depots would have sufficient capacity to cope with the additional business.

Mr Etherington was convinced that the company could maintain or even improve service levels after the depot closes, although he confirmed that the closure would lead to some job losses.

Staff at the Walthamstow depot, were told of the news last Friday. Its 35 drivers will be offered transfers, while other staff have been offered transfers or redundancy packages.

Meanwhile, the long-awaited UK launch of *www.pharmology.com*, UniChem's web site portal for pharmacists, is now expected to take place in April, as an integral part of the Mediphase system.

Mr Etherington said that the Pharmology project, which was first announced at the UniChem convention in Puerto Rico (*C&D* October 7, 2000), had entered into a 'soft launch' phase. The pilot currently involves 25 UniChem customers, with the number expected to be increased to around 300 over the next two months.

At the moment, visitors to *www.pharmology.com* will find that the site has text in French only. Mr Etherington said UniChem had always intended to launch the French site first. The 'hard launch' there is planned for the end of January.

The French site currently features product information, medical information, an e-commerce facility, as well as legal advice. The news section provides the latest information on drug recalls, health issues and an events calendar, as well as a forum enabling users of the site to exchange views.

Pharmacists will be able to access professional information in a password-protected part of the web site.

Mr Etherington said that the English site would be along the same lines, while taking into account the different markets and their particular needs.

The business-to-consumer aspect of Pharmology, including the offer of hosting a pharmacy's own web site, seems less important for French pharmacists. They appear to see the site mainly as a business-to-business portal.

In contrast, their British counterparts are, in Mr Etherington's view, particularly keen on promoting their business and the services it offers to the consumer via the web site.

"The market in France is completely different, pharmacists there have a very ethical image and customers will go into a pharmacy of their own accord to talk to the pharmacist," he said.

He added that feedback from the French pilot had been very encouraging, with the site recording over 670,000 hits from customers since its soft launch in early December.

UniChem is also developing a version for Italy and Spain.

'Harrods of Healthcare' gets £2.6m refit

Lloydspharmacy is spending £2.6 million on refitting its flagship shop, John Bell & Croyden in London, and a company logo will be introduced for the first time. A John Bell & Croyden web site is also under development.

The refit will strike a balance between maintaining the store's historic character and meeting the needs of the present day. Work on the premises is being carried out in eight phases to allow the store to remain open, with a provisional completion date of early June.

Walls have been demolished to bring the two parts of the premises together. Nick Stokes, marketing director for Lloydspharmacy, said customers had previously been treating the two sections as separate entities.

"Customers tended to either shop in the back section, especially those having been referred by the specialist doctors in Harley Street, or they came into the main pharmacy," Mr Stokes said.

The offices towards the back of the store will be moved to the basement to give way to showrooms displaying wheelchairs, special beds and bathroom appliances. There will also be a separate reception area for the special concessions, such as the hearing clinic, the hair clinic and chiropody.

The general concept of wood and leather features will, however, be retained. There will be wood-effect laminated flooring for the walkways throughout the store, while the carpet will reflect John Bell & Croyden's traditional signature colour of dark blue.

Brand new fixtures and fittings have been designed to give the pharmacy a more up-to-date look.

Using coloured lighting filters, a colour-coding system will help customers navigate the large premises.

The dispensary will still be the focal point of the store. In line with Lloydspharmacy's concept for its other stores, the counter will be broken up to allow the pharmacist to come out and talk to customers. P-medicines will be displayed in glass cabinets in front of the dispensary.

Traditional features, such as the huge barometer and ancient porcelain receptacles, will be given prominence. Replicas of Jacob Bell's (son of the founder of JB&C and co-founder of the Royal Pharmaceutical Society) etchings of plants will be incorporated in the dispensary counter.

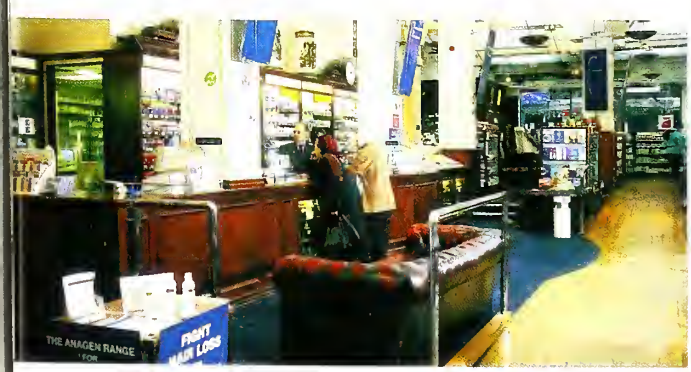
There will still be a separate counter for doctors and healthcare professionals - a concession to the stores proximity to Harley Street. A consultation room and a bathroom with shower will be introduced next to the dispensary.

The refit will give the store a much greater focus on health and beauty. Specialist beauty and skincare products will move from the back of the store to a location near the main entrance.

Mr Stokes said a large part of the investment had gone into research, involving customers, staff and doctors, prior to the refit.

"It's a very special store and as such deserves special treatment," he said.

The average transaction value is £41 and customers sometimes arrive in chauffeur driven cars.



The pharmacy counter will remain the focal point of the store

Free legal advice

Chemist & Druggist's web site - *www.dotpharmacy.co.uk* - has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service - dotLaw - is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists should e-mail their questions to the following address - *pharmlaw@ubmint.com* - with their full name and the name of their pharmacy. These details are for only *C&D*'s records - pharmacists will not be named on publication.

The questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

COMING EVENTS

JANUARY 23

NICPPET, at the Adair Arms Hotel, Ballymena, 7.30 for 8pm.

NICPPET, at Craigavon Area Hospital, Craigavon, 7.30 for 8pm.

Fife Branch, RPSGB, at the Dunnikier House Hotel, Kirkcaldy, 7.45pm.

Bury Branch, RPSGB, at the Macdonald Norton Grange Hotel, Castleton, Rochdale, 7.30 for 8pm.

JANUARY 25

NICPPET, at the Dunadry Hotel, Dunadry, 10am-5pm.

Eastbourne Branch, RPSGB, Eastbourne District General Hospital, 8pm.

Slough Branch, RPSGB, Wexham Park Hospital, Slough, 7.15 for 8pm.

Classified

Appointments £27.00 P.S.C.C. + VAT minimum 3x1. General classified £18.00 P.S.C.C. + VAT minimum 3x2. Box numbers £15.00 extra. Available on request. Copy date 12 noon Tuesday prior to Saturday publication. Cancellation deadline 10a Friday; one week prior to insertion date. All cancellations must be in writing. Contact Debra Thackeray, Chemist & Druggist (Classified), United Business Media Lt Sovereign Way, Tonbridge, Kent TN9 1RW. Telephone 01732 377493, Fax: 01732 377179. Internet: http://www.datpharmacy.co.uk.

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APPOINTMENTS

A NATIONAL PRESCRIBING CENTRE POST

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Project Team Leader – National Medicines Management Services Programme

- **Vacancy reference number: 09/01**
- **Salary range: c £40 - £48k p.a.**
- **Potential for performance review**
- **3 year fixed term NHS contract**
- **Base: NPC - Liverpool, plus a requirement to work at other sites as required**

Medicines Management Services are set to become an important and integral element in the delivery of high quality, patient-centred healthcare in the modern NHS. The 'NHS Plan' and 'Pharmacy in the Future' stated that a major new initiative would be undertaken nationally to develop a range of medicines management services, within every PCG/PCT by 2004.

This advert heralds the start of the formal medicines management programme.

The National Prescribing Centre (NPC) is a high profile and influential NHS body, based in Liverpool. It has a remit to facilitate the promotion of high quality, cost effective prescribing and medicines management through a co-ordinated and prioritised programme of activities aimed at supporting all relevant professionals and senior managers working in the modern NHS.

The National Primary Care Development Team (NPDT) is a new and important national initiative delivering the successful Primary Care Collaborative. This involves practice teams from PCGs and PCTs in optimising the overall experience and clinical outcomes for patients.

Applications are invited for this new and challenging post that provides, for a high-calibre and respected healthcare professional, an exciting career development opportunity to work at the cutting edge of national policy development in healthcare. The successful candidate, most probably a senior pharmacist, will build and lead a carefully selected multidisciplinary project team that will work collaboratively with other national organisations already recognised and respected in the areas of change and medicines management across the NHS.

Applicants should have a strong and demonstrable track record in the promotion and delivery of cost-effective prescribing and medicines use within the NHS and, particularly, primary care. They should demonstrate a clear understanding of the key policies, structures and processes of the NHS, especially as they relate to medicines and pharmacy.

A proven capacity for self-motivation, clarity of thought, strategic planning, effective management of budgets, resources and change is essential, as is the ability to work under pressure and to deadlines. Applicants should also have excellent communication, interpersonal, team-working and diplomacy skills and must be willing to travel extensively around the country.

The successful candidate will be accountable to the Medicines, Pharmacy and Industry Division at the Department of Health (DoH) and will be managed by the NPC's Director. They will have a primary responsibility for managing and delivering the Medicines Management Services Programme to time and within budget.

The successful candidate will also be required to establish close and effective working relationships with a separate national pilot trial of a structured medicines management programme, based exclusively in community pharmacies. The Pharmaceutical Services Negotiating Committee (PSNC) has developed proposals which the DoH is currently negotiating with a view to the initiative starting this year.

For an initial informal discussion about the post, contact Clive Jackson, NPC Director, on 0151 794 8137.

For an application form and job description please call the 24 hour answer phone, 0151 285 2073 quoting the job title, reference number: 09/01, and your name and address, or alternatively, you can e-mail kate.simpson@liverpool-ha.nhs.uk or write to the Human Resources Department, Liverpool Health Authority, Hamilton House, 24 Pall Mall, Liverpool, L3 6AL.

Closing date: 5th February 2001
Interviews are expected to be held during the w/c 19th February 2001.

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For an application pack contact Jean Mclean, the Pharmancy Department, Birmingham Children's Hospital NHS Trust, Steelhouse Lane, Birmingham B4 6ND Telephone 0121 333 9786. Please quote reference TM323/01. Closing date 5th February 2001.

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Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@ubmint.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

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VETERINARY SERVICES

Independent High Wycombe pharmacist and co-founder of the town's Islamic Education Centre, Shabhir Jogiat is a man with a mission – to rescue Asian youth from a very modern malaise. Simon Turner reports

Making a difference

Sickened by an endless and growing trail of young Asian methadone addicts passing through his town centre Priory Pharmacy over a number of years, Shabhir Jogiat realised he was witnessing a serious decline in the morality and well-being of local children and resolved to do something about it.

In 1999 he got together with two partners – Arshad Saahib, a local paediatric consultant, and Imaam Saahib, a professor in Arabic Studies – and established the Muslim Education Centre in a former shop in Totteridge – a place where otherwise aimless children could meet after school hours, and also learn life skills.

The ground floor of the shop was converted into a bookshop and stationery outlet, which pays its way by selling discounted publications and leaflets, while the upstairs was converted into meeting rooms. The Centre's soon filled its capacity of 40 children and, with increasing numbers showing interest, it became necessary to make classes more formal.

"Behind the bookshop are two huge rooms where we hold evening classes, from 4.30 to 7.30pm, and weekend classes," says Mr Jogiat. "We catch kids from five years of age onwards, up to about 19, and educate them in Arabic studies and the Koran."

Normally, classes held in a Madressa are "very strict and confined", which may put some young people off, says Mr Jogiat, who confesses that he is not personally "religiously-minded". The Centre therefore tries to combine religious teaching with a range of other activities.

"We get visiting professors from other towns giving lectures in English about different aspects of life, such as drugs, the Millennium craze, the internet, shares," he explains. "We are trying to broaden the children's knowledge and open their eyes before they get too bogged down with one thing and become confined.

The Muslim Education Centre, established to halt a decline in the morality and well-being of Asian children in and around High Wycombe

We provide them with the means to to see other aspects of the same thing and generally be more informed.

"Another thing we are trying to infiltrate into these kids is the ability to ask themselves, 'How am I spending my time?' Time is so important in this country and youngsters have a lot of it. What are they going to do with it – especially on holidays?

"We had a very good talk recently by a Manchester University lecturer on time-management, how you should spend your time and the way you should spend your time – how you should organise yourself."

Mr Jogiat, a pharmacist since 1981, came to High Wycombe six years ago from Hayes, in Middlesex, where he worked for a period as a locum and, later, for the multiple Kingswood, which was taken over by Lloydspharmacy. Though he enjoyed working for Lloyds, he jumped at the chance to establish his own business when the opportunity arose in 1994.

After tolerating the grind of commuting to High Wycombe for a while, he decided to sell up and move to the town.

Mr Jogiat says his work as a pharmacist and as a volunteer with the Centre often overlap.

Mirroring the 'empowerment-through-knowledge' ethic of the Centre, Mr Jogiat has a separate counter set aside in his pharmacy specifically for dispensing advice – a service which is highly valued by customers and which gives him most job satisfaction of all.

"It doesn't pay me a penny but I am fulfilling a need and achieving something," he says. "People open up better with me and ask additional questions related to their medication. Time is the big limiting factor," he adds. "You could spend all day giving advice and not make a penny."

Mr Jogiat believes part of the problem affecting the Asian community is a communication barrier between the generations; parents simply don't understand the sort of pressures kids are under nowadays. "Most of the elderly people in the community are very sheltered and under the wrong impression that their children are not going to go astray," he says. "But pressures external to the family are too great now. In the six years I've been here I've gone through so many Asian, 20-25-year-old methadone patients. They haven't got a career, they haven't got a life, they have just lost it all," he says.

"But when you look at the parents they are the total opposite; they have come here from the sub-continent and worked hard. They have a house with the mortgage paid, a car and everything.

"When children go astray in a family like that you feel something has gone terribly wrong somewhere; in some way communication was not there. This is what triggered us to set up the Centre."

The Centre is a voluntary organisation and relies on small, regular donations of £5-10 per month. "We are just trustees, there is no financial gain and we can only stretch so far," Mr Jogiat explains. "What we would like is a bigger place, the size of a leisure complex or a school. That way a lot of things could be done in one centre, like have a computer room, library and lecture theatre."

For the moment, those unfortunate enough to miss out on classes can be informed by tape recordings of all the lectures, which are sold in the bookshop for a nominal £1, to cover costs. The Centre is also extending its reach with more modern technology, having recently become a licensed radio broadcaster. Its 'Azaan' base station transmitter can spread the message to thousands of listeners within a 13-mile radius.

The Muslim Education Centre has clearly struck a chord, not least among the dozens of children who now feel they have somewhere worthwhile to spend their time. Mr Jogiat accepts that only time will tell if the initiative will actually prove successful in keeping youngsters on the 'straight and narrow' but one thing is certain; in a very short space of time the Centre has become an integral and fulfilling part of daily life for many people.

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